



MIIX Insurance Company in Liquidation

Authorization to Release Confidential Claim Information

This application must be completed in full and signed by the healthcare provider. Additional blank forms may be obtained from Claims Administration staff by calling 866-670-6449 or you may copy the blank form for future or additional requests. MIIX CLAIM HISTORY REPORTS DO NOT PROVIDE COVERAGE DATES.

There is a \$40.00 fee for a mailed 10-year claim history report and a \$50.00 fee for a faxed and mailed 10-year report. CREDIT CARD PAYMENTS ARE NOT ACCEPTED. If a report from "Date of Inception" is required, please indicate this on the top right of the form in large highlighted letters. Please mail the completed form, along with your check made payable to "MIIX," to:

MIIX Insurance Company in Liquidation
134 Franklin Corner Road, Suite 104
Lawrenceville, NJ 08648

Healthcare provider's name: (Name of healthcare provider (i.e. physician, nurse, PA-C, etc. TYPE OR PRINT CLEARLY))

MIIX Account Number and/or MIIX policy number: Gender M or F

Group or Institution that MIIX policy was written: (i.e. the healthcare provider was insured under a Group or Hospital Policy)

Healthcare provider's current mailing address: Street/P.O. Box / City / State / Zip Code

Phone number: Fax number:

Medical license # * AND last four digits of your Social Security # * THE REPORT WILL NOT BE PROCESSED IF THIS INFORMATION IS OMITTED

I, (Name of healthcare provider, typed or printed), authorize the release of my 10-year Claim History Report to the organization indicated, its designated agents, employees or representatives. I agree to indemnify and hold MIIX harmless for any liability, expense or claims arising out of the release of this information. My signature below authorizes the release of this 10-year Claim History Report. This authorization expires in 60 days from the date signed.

PHOTOCOPIES OF PRIOR YEARS' AUTHORIZATIONS WILL NOT BE ACCEPTED.

Signature of named healthcare provider (NO STAMPED SIGNATURES ACCEPTED)* (Signature date required)* *CLAIM HISTORY WILL NOT BE RELEASED WITHOUT HEALTHCARE PROVIDER'S SIGNATURE OR DATE

To whom should the claim history report be released?

\$40.00 - Mail to: \$50.00 - Fax to: (Fax number of company/facility to receive report)

Company/Facility name:

Attention: Phone #

Address:

City: State: Zip Code:

MIIX and its representatives have taken reasonable steps to ensure the accuracy of the information contained in the Claim History Report. On occasion, there may be an error or omission due to the high volume of data involved. Independent verification with the healthcare provider is recommended. The information provided in no way alters or supersedes any of the terms and conditions of the policy.

134 Franklin Corner Road, Suite 104, Lawrenceville, NJ 08648
(866) 670-6449 (856) 764-0399 Fax

PLEASE DO NOT STAPLE PAYMENT TO THE AUTHORIZATION