Authorization To Release Confidential Claim Information

Physician's Name *(please print)* ______________________________

NJ PURE Policy Number ______________________________

Name of Physician's Group or Institution ______________________________

Physician's Current Mailing Address

Street/P.O.Box ______________________ City ______________ NJ Zip __________

Telephone ______________________ Fax ______________________

Cell ______________________ Pager ______________________

*Last four (4) digits of your Social Security No. [ ][ ][ ][ ]

**This report cannot be processed if this information is not complete.*

I, ____, authorize the release of my claim(s) history
(please print)
to NJPURE, its designated agents, employees or representatives. I agree to indemnify and hold NJ PURE harmless for any liability, expense or claims arising out of the release of this information.

My signature below authorizes the release of this claim history. This authorization expires in 60 days from the date signed unless another date is specified here ____________________. A copy of this signed document is as valid as the original.

______________________________ ______________________________

Signature of Physician (Required–No Stamped Signature Accepted.) *(Signature Date Required)*

Mail Claims History To:

____

____

____

____

____