



AUTHORIZATION TO RELEASE CLAIM HISTORY AND COVERAGE VERIFICATION FORM

Please complete in full for prompt attention. Most requests are processed within 2-3 business days of receipt. Additional copies of this form can be obtained on the web site: www.promutualgroup.com/physicians/claims.php. You may also use your own form as long as it contains identifying information and is duly signed and dated.

There is a \$30 fee* for a Loss History report. Please send the completed form and a check payable to **ProMutual Group** to:

ProMutual Group
Claim Information & Reporting Unit
101 Arch Street
P.O. Box 55178
Boston, MA 02205-5178

***Current insureds receive one report free per calendar year. All others requests will be assessed a \$10 charge.**

Type or Print Name of Provider: _____

Name of Group or Organization: _____

Current Mailing Address: _____

Phone Number: _____ Medical License Number **and/or** Social Security #: _____

Policy #: _____ Account Number (if known): **A** _____ NPI #: _____

Reports are sent by regular mail. Mail the Loss History and Coverage Verification Report to:

Company/Organization Name: _____

Mailing Address: _____

I authorize the release of my coverage and claim history to the organization indicated above.

This authorization expires 30 days from the date signed unless another date is specified here: _____

Signature of Provider
(NO STAMPED SIGNATURES ACCEPTED)

Signature date **(REQUIRED)**

ProMutual Group has taken reasonable steps to ensure that the information contained on claim loss history reports is accurate. On occasion there may be an error or omission due to the high volume of data involved. Verification of the content by the provider is recommended before action is taken upon the information by the recipient.