# Authorization to Release Coverage Verification/Claim History

Legibly complete in full for proper and prompt processing.
Requests are processed in the order they are received. Typical processing time is 1 to 2 weeks.

## Complete to ensure processing of proper individual (all fields required):

Practitioner's full name: _____

Current phone #: _____

Current mailing address: _____

City: _____ State: _____ Zip Code: _____

Carrier for Policy: _____ Policy #: _____

## Please send my reports to (all fields required):

Company Name: **Willow Risk Advisors, Inc.**

Attention to: Bridget Oltman

Address: 350 S. Main Street Ste 101

City: Doylestown State: PA Zip Code: 18901

**RETURN COMPLETED FORM TO: Bridget@willowrisk.com or FAX to 267-448-5247**

## I authorize (carrier name) to release my claim/coverage history to the above entity.

_____ _____

**Practitioner's Signature (NO STAMPED SIGNATURES)** **Date**

**RETURN COMPLETED FORM TO: Bridget@willowrisk.com or FAX to 267-448-5247**