Authorization to Release Confidential Claim Information

*This application **must be completed in full** and signed by the healthcare provider. You may want to make copies of this form before it is completed so you have a supply for future or additional requests. Additional copies may also be obtained through our website at www.MDAdvantageonline.com. Please direct questions to Policyholder Services at 888-355-5551.*

If the healthcare provider is no longer an MDAdvantage insured, include a check for $35 made payable to MDAdvantage with this form and mail to:

MDAdvantage
Claims Department
100 Franklin Corner Road
Lawrenceville, NJ 08648-2104

Is the healthcare provider a current MDAdvantage insured? Yes ☐ No ☐

Note: The $35 fee is not required for current insureds. Only the completed authorization form is required and may be faxed to 978-244-5205.

Medical Professional Liability Claim History ☐ Supreme Advantage Claim History ☐ Both ☐

To whom should the claim history report be released?

☐ Mail to: ☐ Fax to: 609-520-0225
(Fax number of company/facility to receive report)

Company/Facility name: NJ PURE

Attention: _____ Dept: _____

Address: 214 Carnegie Center Suite 101

City: Princeton State: NJ Zip Code: 08540

Healthcare provider's name: _____
(Name of healthcare provider, typed or printed)

Account Number(s): _____ or MDAdvantage policy number: _____

Name on Policy: _____

Healthcare provider's current mailing address:

_____/_____/_____/_____
Street/P.O. Box City State Zip Code

Phone number: _____ Fax number: _____

Medical license and / or Social Security #: _____/_____- - _____

I, _____, authorize the release of my claim history to the
(Name of healthcare provider, typed or printed)

organization indicated above, its designated agents, employees or representatives. I agree to indemnify and hold MDAdvantage 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 30 days from the date signed unless another date is specified here_____.

_____ _____
Signature of named individual (*NO STAMPED SIGNATURES ACCEPTED*) (signature date **required**)

MDAdvantage and its representatives have taken reasonable steps to ensure the accuracy of the information in the report. Errors or omissions may occur due to the high number of requests and the volume of data involved. Independent verification with the healthcare provider is strongly recommended. The information provided in no way alters or supersedes any of the terms and conditions of the policy.