NJ PURE

Integrity ▪ Transparency ▪ Stability

Authorization to Release Confidential Claim Information

Healthcare Provider's Information

Name (please print): _____

NJ PURE Policy Number: _____

Group or Institution: _____

Current Mailing Address:

Street/PO Box: _____ City: _____ State: ____ Zip: _____

Telephone: _____ Fax: _____ Cell: _____ Pager: _____

*Last four (4) digits of your Social Security No. __ __ __ __ (required)

Company/Facility to Whom the Claim Information will be Released

Name: _____ Dept: _____

Attn: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

Healthcare Provider's Authorization

I, _____, authorize NJ PURE to release my claim(s) history to the organization listed above, 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 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 Healthcare Provider (Required–No Stamped Signature Accepted.) *Date (Required)*

NJ PURE and its representatives have taken reasonable steps to ensure the accuracy of the information contained on claims history reports. 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.

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