Ascension

PROVIDER'S AUTHORIZATION TO RELEASE CLAIM & INSURANCE HISTORY

Provider: Please complete the below form and attach via e-mail to the Credentialing or Risk Management department of your health ministry for release of claims history/insurance verification for credentialing purposes. Verification of your electronic submission by the above department shall constitute your acknowledgement of the below release from liability in lieu of signature.

Date: _____

Provider's Name: _____

Email Address: _____

Phone Number/Fax: _____

Social Security (Last 4 Digits Only): _____

Date of Birth: _____

Authorization to Release Information

I hereby authorize _____ and its representatives to release my
(Health Ministry Name)

Claims History and Insurance Verification to _____.
(Requester Name)

Release from Liability. I hereby release _____ and its representatives
(Health Ministry Name)

from liability for their acts performed in good faith and without malice in connection with the collection, release and exchange of, and reliance upon, information used in accordance with this request.

Requester Information *(if different from Provider) – complete below or attach letter from requester*

Name of Credentialing Requester: _____

Title/Department: _____

Company Name: _____

Address: _____

City/State/Zip: _____

Email Address: _____

Phone/Fax Number: _____

Signature: _____ Date: _____