The GW Medical Faculty Associates

REQUEST FOR CLAIMS HISTORY

Name of provider, including designation (please print):

_____

Dates of employment at MFA: _____
If you are a resident, please indicate the dates of residency

Department /Title: _____

Contact information:

Email: _____

Telephone: _____ Fax:_____

Address: _____

_____

_____

How do you wish to be contacted?

If you choose email, please ensure that the email address provided above is valid

I acknowledge and understand that in order to protect the confidentiality of this information, Claims History letters will only be sent to the insured provider. The information may be sent to others if the appropriate authorization is provided.

Signature of provider/requestor: _____

Date: _____

Please email this form to: MFA-Office of the General Counsel- Risk Management
insurance@mfa.gwu.edu

******If there is a credentialing request form you wish us to respond to, please attach a copy so that we may provide accurate information that is responsive to the specific question(s) asked.******