



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?  Email  Telephone  Fax  U.S. Mail

\*\*\*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 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](mailto: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.\*\*\***