



PATIENT: \_\_\_\_\_  
EMPLOYEE: \_\_\_\_\_  
CLAIM NO: \_\_\_\_\_  
PROVIDER: \_\_\_\_\_

GROUP NO: \_\_\_\_\_  
ACCT NO: \_\_\_\_\_  
INCURRED: \_\_\_\_\_  
CHARGE: \_\_\_\_\_

RE: Request for Names of Physicians Seen

To Whom It May Concern:

We have received a claim from the provider listed above. In order to complete the processing of this claim, we require the names and addresses of all healthcare providers seen by this patient between \_\_\_\_\_ and \_\_\_\_\_. Please enter this information below.

NAME OF PROVIDER	COMPLETE ADDRESS
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Your signature: \_\_\_\_\_ Date: \_\_\_\_\_

If the patient was Not treated within the dates specified above, please indicate below; sign, date and return to our office.

Not treated \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

The requested information must be received by HealthComp within forty-five (45) days from the date of the initial request or the claim will be denied/closed. If you have any questions, please contact our office at (800) 442-7247 or Fax (559) 499-2464.

Sincerely,

HealthComp Administrators  
Claims Department