PROVIDER VERIFICATION OF INSURANCE REQUEST FORM

REQUESTOR INFORMATION		RETURN COMPLETED REQUEST Form TO:
REQUESTED BY:		West Virginia University Attn: Risk Management E-mail Address Link: verification@hsc.wvu.edu
DATE REQUESTED:		
PHONE:		
E-MAIL:		
FAX:		

PROVIDER DETAILS					
PROVIDER NAME:					
PROVIDER TYPE:	MD ☐	DO ☐	NP ☐	PA ☐	Other:
	Currently Employed Provider?			Yes	No
	New Provider?			Yes	No
				Start Date:	
	Previously Employed Provider?			Yes	No
	Name Resident/Student program?			Yes	No
PROVIDER STATUS:	Full Time	Part Time	Resident	Contracted	Other:
	CONTRACTED PROVIDER INFORMATION				
	If contracted, provide copy of contract		CONTRACT NAME:		
			CONTRACT NUMBER:		
			ADDITIONAL NOTES:		

REQUESTED DOCUMENTATION			
	Verification of Insurance:	Yes	No
	Prior Years/Loss Run From Year:	to Year:	