INSURANCE VERIFICATION or CLAIMS HISTORY REQUEST

Please attach this form for all requests.

Today's Date: __________________________

Please Check One:

☐ Credentialing Request (Insurance Verification & Claims History)
  Hospital Credentialing Requests, to include verification of
  insurance and/or claims history (with release attached) should be
  sent to: credentialing@amsrrg.com

☐ Loss Run (For Renewal Purposes) should be sent to Melissa Carty:
  mcarty@bpmp.com

☐ Insured  ☐ Broker  ☐ Other _________________________________

1. Requester: _____________________________________________

2. Requester’s Email: (REQUIRED) _____________________________

3. Requester’s Telephone Number: _____________________________

4. Name of Insured: _________________________________________

5. AMS Policy Number: ______________________________________

6. Policy Inception Date: _____________________________

7. Policy Expiration Date: _____________________________

Additional Notes: __________________________________________

Produced By:

AMS Management Group

Policy Administrative Office: 23 Route 31 North, Suite A-20, Pennington, NJ 08534  tel: (866) 461-1221  fax: (609) 737-1186

ED.11/2017