CAMC HEALTH SYSTEM, INC.
AND AFFILIATES
SELF-INSURANCE TRUST

501 Morris Street
Post Office Box 3669
Charleston, WV 25336
304-388-6787 (Phone)
304-388-6027 (Fax)

To expedite requests for insurance verification, the following information is required from the requesting party before verification of coverage will be provided. Please submit this form to the address listed above or if by interdepartmental mail, Office of the General Counsel, CAMC General Hospital.

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|---|---|
| Name of person (including Social Security No.) or entity for which coverage needs to be confirmed: | |
| Position(s) and complete date(s) (month/day/year) of employment in each position (past/present): | |
| Entity the person is/was employed by: Charleston Area Medical Center, Inc., CAMC Teays Valley Hospital, Inc., CHERI, etc. | |
| Name, address, contact information and email address of person/place requesting coverage verification: | |
| | |
| Professional or general liability coverage: | |

An authorization for release of information signed by the person whose insurance coverage is being verified must be attached to this form. If a release is not available, please have them sign the following statement:

I, (Print) _____, give my permission/authorization for the release of the above information.

_____ _____
Signature Date

Claims History: ☐ Yes
☐ No

01/11/10