MIIX Insurance Company in Liquidation

Authorization to Release Confidential Claim Information

*This application **must be completed in full** and signed by the healthcare provider whenever you are requesting claim history information. Make copies of this form before it is completed so you have a supply for future or additional requests. Additional copies can be obtained from Claims Administration staff at 866-670-6449.*

There is a $40.00 fee for a mailed claims history; a $50.00 fee for a faxed and mailed claims history. Please complete this form and include your check made payable to "MIIX", and mail to:

MIIX Insurance Company in Liquidation
2271 Route 33, Suite 105
Hamilton, NJ 08690

Healthcare provider's name: ____
(Name of healthcare provider, **TYPED OR PRINTED**)

MIIX Account Number and/or MIIX policy number: ______________________________ Gender M or F

Name of Group or Institution that MIIX policy was written: ____

Healthcare provider's current mailing address:

____________________________________ /________________________ /_________ /_______________
Street/P.O. Box City State Zip Code

Phone number: _______________________________ Fax number: _______________________________

Medical license # ____________________AND last four digits of your Social Security #☐☐☐☐*
***THIS REPORT CAN NOT BE PROCESSED IF THIS INFORMATION IS NOT FILLED OUT**
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I, ____, authorize the release of my claim history to
(Name of healthcare provider, typed or printed)

the organization indicated, its designated agents, employees or representatives. I agree to indemnify and hold MIIX harmless for any liability, expense or claims arising out of the release of this information.

My signature below authorizes the release of this claim history. This authorization expires in 60 days from the date signed unless another date is specified here ____________________. **Also no photocopies of this form from prior years will be accepted.**

____ ___________________________
Signature of named individual (*REQUIRED - NO STAMPED SIGNATURES ACCEPTED*) **(Signature date required)***
***CLAIM HISTORY WILL NOT BE RELEASED WITHOUT THE SIGNATURE OR SIGNATURE DATE**
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To whom should the claim history report be released?

☐ **$40.00 - Mail to:** ☐ **$50.00 - Fax to:** ____
(Fax number of company/facility to receive report)

Company/Facility name: ____

Attention: ____

Address: ____

City: _________________________________ State: __________ Zip Code: _______________________

MIIX and its representatives have taken reasonable steps to ensure the accuracy of the information contained in the claim history report. On occasion, there may be an error or omission due to the high volume of data involved. Independent verification with the healthcare provider is recommended. The information provided in no way alters or super cedes any of the terms and conditions of the policy.