PCRM Pacific Centre for Reproductive Medicine

Insurance Investigation Consent

Please complete and fax to: 780.990.4443 Attn: PCRM Pharmacy

Patient Stamp	Patient Insurance Card

Insurance carrier:

ID number:

Group number:

Primary cardholder name:

(For office use)

Total lifetime coverage:

Co-payment (%):

Electronic submission yes no

□ Pre-authorization required

Comments:

I verify that the information that is provided in this consent form is complete and accurate. I hereby give permission to the physicians of PCRM, PCRM Pharmacy staff, or their employee delegate, to contact my insurance carrier to obtain my policy information pertaining to my coverage for fertility medication.

Dated this _____ day of _____, 20_____

Name: _____

Signature: _____