univera HEALTHCARE

Prior Coverage Verification Form

1- Subscriber Information

IDENTIFICATION NUMBER		
SUBSCRIBER'S LAST NAME	SUBSCRIBER'S FIRST NAME	INITIAL
SUBSCRIBER ADDRESS		
CITY	STATE	ZIP CODE

2- Prior Coverage Information

NAME OF PREVIOUS INSURANCE CARRIER: _____

EFFECTIVE DATE OF PREVIOUS COVERAGE: _____

TERMINATION DATE OF PREVIOUS COVERAGE: _____

NOTE: **Please attach a copy of your Certificate of Coverage to this form.**

3- Signature and Date

I certify that the information submitted is accurate to the best of my knowledge.

SIGNATURE:_____ DATE:_____

Please ensure that all sections are complete, signed and dated prior to returning. Failure to supply all of the required information may result in delayed processing and/or subsequent return or denial of this request.

Please return completed form to: **Univera Healthcare**
P.O. Box 211256
Eagan, MN 55121