**Application for chronic prescription medicine**

Staff #

Insured’s name

Mobile #

Company/group

Date of birth

Membership #

I hereby certify that all the information and documents submitted with this form are complete and true. I hereby authorize any doctor, hospital, clinic, medical provider, insurance company, institution, or any other person who has records or information about me to provide Seib Insurance with complete information, including copies of medical records related to any illness, accident, treatment, examination, advice, or hospitalization.

 Name of patient/insured Signature Date

To be completed by a treating/attending physician

 Diagnosis Time (year of diagnosis)

Important note: Please attach copies of current laboratory reports (if available)

Name of medication (generic & brand name) Dose Frequency Duration

Where does the patient want to receive his/her medication?

(please specify the name of the provider)

Attending physician’s name Specialty

Stamp & signature of

attending physician Date

**To be completed by a Seib Insurance medical officer- CSC**

 Approved by Dr. Signature Date