PCRM
PACIFIC CENTRE FOR REPRODUCTIVE MEDICINE

Insurance Investigation Consent

Please fill and fax to 604.434.5522 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, 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: ______________________