



Atlantic American Employee Benefits

Attn: Claims Operations Department
 4370 Peachtree Road NE, Atlanta, Georgia 30319
 Phone: (866) 458-7502

Medical Information Request Form

INSURED NAME		POLICY/CERTIFICATE NUMBER
(First, Middle & Last)		
Please provide the names, complete addresses and telephone numbers of all physicians, hospitals and pharmacies who have treated or dispensed medication to the insured within the last 5 years in the area below.		
1. PRIMARY CARE PHYSICIAN		Telephone Number
Street Address		Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)		Date Last Seen Mo. _____ Yr. _____
2. PHARMACY NAME		Telephone Number
Street Address		
(City, State & Zip Code)		
3. HOSPITAL/CLINIC		Telephone Number
Street Address		Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)		Date Last Seen Mo. _____ Yr. _____
4. NURSING HOME		Telephone Number
Street Address		Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)		Date Last Seen Mo. _____ Yr. _____
5. OTHER PROVIDER	Telephone Number	Medical Specialty
Street Address		Date First Seen Mo. _____ Yr. _____
(City, State & Zip Code)		Date Last Seen Mo. _____ Yr. _____

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*If additional space is required please use a separate sheet of paper. The more complete the information the quicker we will be able to conclude our review.