Willamette Valley Benefits, Inc.
Medical Review Form

Name:_____ DOB: _____Gender:_____

Preferred Effective Date: _____

Address: _____ APT#/Suite #: _____

_____ County: _____

Phone: _____ Tobacco: Y☐ N☐

Current Insurance Plan: _____

Preferred Email:_____

By providing your e-mail you are authorizing Willamette Valley Benefits, Inc. to include you on our e-mail list and receive periodic e-mails from Willamette Valley Benefits, Inc.

Preferred Pharmacy: _____

By returning this completed form, you are agreeing to have a representative of Willamette Valley Benefits, Inc. contact you regarding the information you provide below.

In the next few lines please provide a list of your doctors and their phone numbers if available.

Hospital and Doctor's Name	Doctor's Phone Number

Pharmacy and Prescriptions	Dosage	Per Day

Please return to:
Willamette Valley Benefits, Inc.
6400 SE Lake Road, Suite 210
Milwaukie, OR 97222

Phone: 503.659.5566
Toll Free: 1.888.944.4644
Fax: 503.659.5992

How did you hear about Willamette Valley Benefits?_____

If Already a client of Willamette Valley Benefits who is your insurance agent?_____