

Willamette Valley Benefits, Inc. Medical Review Form

Name: _____ DOB: _____ Gender: _____
 Address: _____ Preferred Effective Date: _____
 _____ APT/Suite#: _____
 _____ County: _____

Check box if this is a new address, e-mail or phone number.

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.

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	
Hospital:		
Primary Care Physician:		
Specialists:		
Preferred Retail Pharmacy		
*Pharmacy:		
Prescriptions	Dosage	Per Day

If you have additional Doctors or Prescriptions, please attach a list to this review form.

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? _____