Willamette Valley Benefits, Inc.
Medical Review Form

Name:________________________________ DOB:_____________ Gender:__________

Preferred Effective Date:__________________

Address:________________________________ 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.

Hospital & Doctor's	Doctor's Phone Number
Hospital:	
Primary Care Physician:	
Specialists:	

Preferred Retail Pharmacy			
***Pharmacy**			
Prescriptions	**Dosage**	**Per Day**	**Brand/Generic**

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
www.wvbenefits.com

How did you hear about Willamette Valley Benefits?________________________________

If already a client of Willamette Valley Benefits who is your insurance agent?__________________

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.