Request for Insurance Verification/Coverage History

Please complete all fields.

Note: To take full advantage of this form's features, JavaScript needs to be enabled. However, it is not required to complete the form.

Coverage Information

Provider's PA License #

Examples: MD-456789, MD-123456-E, HS-123456-L, NC-123456-L.

Provider's Full Legal Name:

Beginning Year: Ending Year:

Check this box for the entire history.
1976 - 2024

Delivery Information

- Supply the e-mail address to which you want Mcare to send the requested document.

E-mail Address:

Example: mcare@pa.gov

Confirm E-mail Address:

Requestor Information

I ATTEST that I am the undersigned and that I am duly authorized to make this request. I further ATTEST that the statements contained herein are true and correct to the best of my knowledge and belief, and that any false statements are subject to the penalties of 18 Pa.C.S. Section 4904, relating to unsworn falsification to authorities.

Type your full name (this is considered to be your electronic signature):

Date:

Telephone Number:

Enter numbers only.

Extension (if any):

Enter numbers only.

To Submit

1. Click the "Review" button to verify information.
2. Click the "Submit" button to open an e-mail that includes the prepopulated e-mail address, subject line, e-mail body, and attachment. **Note: If the Submit button does not work, e-mail the required documentation to RA-IN-CLAIMCOVERAGEINFO@pa.gov.**
3. **If the requestor is not the health care provider**, also attach an authorization, attestation and release form signed by the health care provider (electronic signature is acceptable and the date must be within one year at the time of the request).
4. Click "Send" from the e-mail message window.

For assistance, please email RA-IN-CLAIMCOVERAGEINFO@pa.gov or call 717-783-3770, Option 2 for Coverage.