Pay Practice Direct Form

Member Information

Member Name: ______________________

Your Pet's Name: ______________________

Policy Number: ______________________

Your Email Address: ______________________

Preferred Telephone Number: ______________________

Mobile Home Work

Signature: ______________________

Date: __________
MM / DD / YY

To be Completed by Veterinary Practice

I, ______________________ *(Practice Representative)* **request that any reimbursement for treatments, taking place on** __________ *(treatment date)* **be made payable to** ______________________ *(Practice name)*.

MM / DD / YY

I, as the Practice Representative, understand that all reimbursement requests will be paid within policy limits, any amounts in excess of the member's coverage should be collected from the member directly.

I also understand that once the reimbursement request has been processed, the reimbursement amount will be made payable via cheque and mailed to the address on file.

Practice Representative's Signature:

____

____
MM / DD / YY

PRACTICE STAMP:
(Please include Practice address and phone number)

To be Completed by Member

I, ______________________ **would like to request that any reimbursement for treatments taking place on** __________ *(treatment date)* **be made payable to** ______________________ *(Practice name)*.

MM / DD / YY

Member's Signature:

____

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MM / DD / YY

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