# Medical Visit Verification

Accessia Health requires the information listed below in justification for a payment request by your patient. A staff member of the providers' office must complete and sign the form. Submit the completed form to Accessia Health via secure portal upload, mail, email assistance@accessiahealth.org, or fax 804-744-9388.

## Part A: Patient Visit Information *(To be completed by Provider)*

Patient Name: _____

Date of Birth: _____ Patient ID or Last 4 digits of SSN: _____

Visit Date: _____

Associated Diagnosis: _____

Associated Medication (if applicable): _____

## Part B: Provider Information & Certification *(Please print)*

Provider Name: _____

Facility or Practice Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Name of person completing this form: _____

Title of person completing this form: _____

By signing this form, I certify that the information above is accurate.

Signature of person completing form: _____ Date: _____ / _____ / _____