

Name:

Address:

Phone#:



**Locations in Connecticut and Florida**

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[patty@truecareinsurance.com](mailto:patty@truecareinsurance.com)

In Order to determine if your Provider is in a plan's Network or to determine if your Prescription Medication is on a plan's formulary, Please provide the information requested below. Thank you.

Doctor's Name & Specialty	Address or Phone #	Prescription Name	Prescription Dosage	Hospital Name
				<b>Lab Name</b>

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