Date: ___/___/___

Attention HR Department,

Employer Name: _____

Mailing Address: _____

City/ST/Zip: _____

Dear Human Resources Department,

Please send, either on paper or via digital means, a copy of the following to my medical provider listed below. It is important that my medical provider's office get this data as they are assisting me with filing of my medical claims as well as any necessary appeals. Please include a copy of this page with whatever you send to the clinic so they will link me with what you send.

1. Health Insurance Plan
2. Summary Plan Documents
3. Summary of Benefits & Coverage

Thank you in advance,

Employee Name: _____ DOB ___/___/___

Employee Signature: _____

Clinic Patient Account Number: _____

Clinic Name: Women's Mental Health Specialists

Mailing Address: 301 S Perimeter Park Drive Ste 100 Nashville, TN 37211

Email: hello@WMHS.sprucecare.com