PATIENT SERVICES
INCORPORATED

Medical Visit Verification

The information below may be requested to accompany a payment request. This form must be completed by the patient's medical provider and may be submitted to PSI via secure portal upload, encrypted email, fax, or mail.

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

Patient Name: _____

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

Service/Visit Date: _____

Associated Diagnosis: _____

Associated Medication (if applicable): _____

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

Provider Name: _____

Facility 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.

Provider's Signature: _____ Date: _____ / _____ / _____

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