Reading School District Medical Plan of Benefits
Verification of Annual Physical Examination

I hereby certify that I have examined the individual referenced below at his / her request for a routine physical examination.

Patient's Name: _____

Patient's ID Number: _____

Date of Examination: _____

Physician's Name (Please Print): _____

Physician's Signature: _____

This form may be submitted with the member's claim at time of billing or may be mailed to:

Benefits Office ATTN: Denise Templin