

**DO NOT SEND THIS FORM TO CAMERON AND ASSOCIATES, INC.  
PLEASE SEND TO THE INSURANCE COMPANY**

**10 Year Liability History Request**

**Dear Insurance Provider:**

The following provider of behavioral healthcare services has applied for credentialing or recredentialing with Cameron and Associates, Inc. network of providers. Please forward a 10 year liability history to:

**CAMERON AND ASSOCIATES, INC.**

**Attn: Provider Relations**

6100 Lake Forrest Drive

Suite 550

Atlanta, Georgia 30328

Provider Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Group Name: \_\_\_\_\_

Provider Address: \_\_\_\_\_

Provider Telephone Number: \_\_\_\_\_

Current Professional Liability Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Effective Date Current Policy: \_\_\_\_\_

***Permission to release information:***

I, \_\_\_\_\_, hereby give permission for an appropriate representative of \_\_\_\_\_ (Liability Insurance Company Name.), to release information concerning my liability status during the past ten years of professional practice of behavioral healthcare.

\_\_\_\_\_  
Provider Signature

\_\_\_\_\_  
Date