

# Pay Practice Direct Request Form

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## Personal Information

Member Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Your Pet's Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Your Email Address: \_\_\_\_\_ Preferred Telephone Number: \_\_\_\_\_  
Mobile Home Work

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## To be Completed by Veterinary Practice

I, \_\_\_\_\_ (Practice Representative) request that any reimbursement for treatments, taking place on \_\_\_\_\_ (treatment date) be made payable to \_\_\_\_\_ (Practice name).  
MM / DD / YY

I, as the Practice Representative, understand that all reimbursement requests will be paid within policy limits, any amounts in excess of the member's coverage should be collected from the member directly.

I also understand that once the reimbursement request has been processed, the reimbursement amount will be made payable via cheque and mailed to the address on file.

Practice Representative's Signature:

\_\_\_\_\_  
MM / DD / YY

**PRACTICE STAMP:**

(Please include Practice address and phone number)

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## To be Completed by Member

I, \_\_\_\_\_ would like to request that any reimbursement for treatments taking place on \_\_\_\_\_ (treatment date) be made payable to \_\_\_\_\_ (Practice name).  
MM / DD / YY

Member's Signature:

\_\_\_\_\_  
MM / DD / YY