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:

The Loomis Company
Attn: Jacki Keller
P.O. Box 7011
Wyomissing, PA 19610

OR

Email this form directly to:

kellerj@readingsd.org
or
jkeller@loomisco.com