Patient's Name: _____ Policy #: _____

**SUPPLEMENTAL PHYSICIAN'S STATEMENT TO BE COMPLETED BY TREATING PHYSICIAN**

Physician's name: _____ Phone number: (  ) _____

Specialty: _____

Address: _____

**Accident Claims:**

1. Diagnosis: _____ 2. Diagnosis code(s): _____
3. Was this condition due to an accidental injury? ❑ Yes ❑ No 4. Date accident occurred: _____
5. Nature of the injury: _____
6. Where did the injury happen? _____
7. Date patient first consulted you for this condition: _____ Date of most recent exam: _____
8. Has the patient ever had the same or similar condition? ❑ Yes ❑ No If Yes, when? _____
9. Describe any other disease or infirmity affecting the present condition: _____
10. Referring physician's name, address and phone number: _____
11. Was the patient under the influence of any intoxicant or narcotic at the time of the accident? ❑ Yes ❑ No
    If Yes, was it taken under the direction of a physician? ❑ Yes ❑ No If Yes, please explain: _____
    Did it contribute to the injury? ❑ Yes ❑ No If Yes, please explain: _____
12. Was the patient hospitalized solely due to this condition? ❑ Yes ❑ No
    If hospitalized, name and address of the facility: _____
    Date admitted: _____ Date discharged: _____
13. List any applicable CPT procedure codes: A) _____ B) _____ C) _____
14. Do you have records on the patient's past medical history? ❑ Yes ❑ No

**Intensive Care Claims:**

1. Has the patient **ever** been diagnosed with or treated for a heart attack, heart disease or stroke? ❑ YES ❑ NO
2. Date of first diagnosis: _____ 3. Date of first treatment: _____
4. Was the patient ever diagnosed with the above condition prior to this admission? ❑ YES ❑ NO
   If YES, when? _____
5. List any specific dates of Intensive Care Unit confinement: _____
6. Has the patient ever been diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ❑ YES ❑ NO If YES, when? _____

_____ _____
Completed by (please print) Position

_____ _____
Physician's Signature Date