SUPPLEMENTAL PHYSICIAN'S STATEMENT TO BE COMPLETED BY TREATING PHYSICIAN

Patient's Name: ______________________ Policy Number: ______________________

1. Has the patient **ever** been diagnosed with or treated for heart disease, a heart attack, or stroke? ❑ YES ❑ NO

   If YES, date of first diagnosis: ______________ Date of first treatment: ______________

2. List Diagnosis Code(s): A) ______________ B) ______________ C) ______________

3. List reason for hospitalization: ______________________

4. Was the patient ever diagnosed with the above condition prior to this admission? ❑ YES ❑ NO

   If YES, when? ______________________

5. Was patient hospitalized solely due to this condition? ❑ YES ❑ NO

   If YES, name & address of facility: ______________________

   Date admitted: ______________ Date discharged: ______________

6. List any applicable surgical CPT procedure codes: A) __________ B) __________ C) __________

7. List any other applicable procedure codes: A) __________ B) __________ C) __________

8. List any specific dates of Intensive Care Unit confinement: ______________________

9. Do you have records of the patient's past medical history? ❑ YES ❑ NO

10. Has the patient ever been diagnosed with AIDS/ARC? ❑ YES ❑ NO If YES, when? __________

Physician's Information:

Physician's Name: ______________________

Specialty: ______________________

Address and phone number: ______________________

Completed by (please print): ______________ Position/Title: ______________

Physician's Signature: ______________________ **Date:** ______________