Patient's Name _____ Policy #_____

PHYSICIAN'S STATEMENT TO BE COMPLETED AND SIGNED BY THE TREATING PHYSICIAN

Reason for Hospital Confinement: _____

Admission Date: _____ Discharge Date: _____

Diagnosis: _____ Diagnosis Codes: _____

Do you have records on the patient's past medical history? □ Yes □ No

Was the patient hospitalized solely due to this condition? □ Yes □ No

Has the patient ever had the same or similar condition? □ Yes □ No

If Yes, date Diagnosed: _____

Was the condition due to an accident? □ Yes □ No

If Yes, date of accident: _____

Describe the nature of the injury or condition: _____

_____

Describe any other disease or infirmity affecting present condition: _____

_____

Was the patient under the influence of any intoxicant or narcotic? □ Yes □ No

If Yes, was it under the direction of a physician? □ Yes □ No

If Yes, please explain: _____

_____

Did the intoxicant or narcotic contribute to the patient's injury or condition? □ Yes □ No

If Yes, please explain: _____

_____

List any applicable procedure codes: _____

Physician's Information:

Physician's Name: _____

Specialty: _____

Address and Phone Number: _____

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

Physician's Signature: _____ **Date:** _____