APPENDIX C - 5

ATTENDING PHYSICIAN'S REPORT

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DATE	PATIENT'S NAME	ACCIDENT DATE	FILE NO.

THIS PHYSICIAN'S STATEMENT MUST BE COMPLETED BY THE ATTENDING PHYSICIAN BEFORE BENEFITS THAT MAY BE DUE THE PATIENT CAN BE DETERMINED. PLEASE RETURN THE COMPLETED FORM TO:

CLAIMS DEPARTMENT

1. PATIENT'S NAME AND ADDRESS

2. AGE	3. SEX	4. OCCUPATION (IF KNOWN)

5. HISTORY OF OCCURRENCE AS DESCRIBED BY PATIENT

6. DIAGNOSIS AND CONCURRENT OR CONTRIBUTING CONDITIONS *

7. WHEN DID SYMPTOMS FIRST APPEAR?	8. WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION?
DATE:	DATE:

9. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?
YES ☐ NO ☐ If "YES" state when and describe *

10. IS CONDITION SOLELY A RESULT OF THIS ACCIDENT?
YES ☐ NO ☐ If "NO", Explain *

11. IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT?
YES ☐ NO ☐

12. WILL INJURY RESULT IN PERMANENT DISFIGUREMENT OR DISABILITY?
YES ☐ NO ☐ If "YES", describe

13. PATIENT WAS DISABLED (Unable to work)	14. IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK:
FROM: THROUGH:	

15. REPORT OF SERVICES *

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF SURGICAL OR MEDICAL SERVICE RENDERED	CHARGES
			$
			$
			$
		TOTAL CHARGE TO DATE	$

16. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION?	
YES ☐ NO ☐	**ESTIMATED FUTURE CHARGES** $

DATE	PHYSICIAN'S NAME (PRINT)	PHYSICIAN'S SIGNATURE	IRS/TIN IDENTIFICATION NO

NO.	STREET	CITY OR TOWN	STATE	ZIP CODE

* Use Reverse Side If Additional Space Is Needed

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