



Accidental Injury/Sickness Claim

Attending Physician's Statement

(Please print – Attach separate sheet if additional space required)

INSURED INFORMATION

Insured's Name _____ Soc. Ins. No. ____ - ____ - ____ Date of Birth ____/____/____ Marital Status _____

Insured's Address _____ Phone No. (H) _____

_____ Phone No. (W) _____

Name and address of Regular Employer _____

Policy Number (Required) _____ Insured's Occupation _____

CLAIM INFORMATION

Date of accident/sickness: ____/____/____ Date of first treatment: ____/____/____

Please describe in detail the nature of the Insured's injuries/sickness, including all applicable ICD-9-CM codes:

Was the accident related to the Insured's regular occupation or their fire department activities, and if so how? _____

Was the Insured hospitalized? _____ If yes, please list the names and addresses of all hospitals and all admission/discharge dates:

Did the Insured have any injury or illness prior to the accident that contributed to the accident or to the Insured's present condition? ____

If yes, please describe: _____

Were any surgical procedures performed? _____ If yes, please list all procedures, including applicable CPT4 codes and dates performed:

What are the Insured's current subjective symptoms? _____

What are the objective findings? (please include results of current x-rays, lab tests, etc.,)? _____

Dates of total disability:

Dates of partial disability:

From: ____/____/____ through: ____/____/____

From: ____/____/____ through: ____/____/____

Date Insured able to return to work: ____/____/____

Was the Insured seen by any other physician? _____ If yes, please list the names and addresses of all other physicians: _____

ATTENDING PHYSICIAN INFORMATION

Name of Attending Physician: _____ Phone No. _____

Address: _____

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Attending Physician) _____ DATE ____/____/____