

PHYSICIAN'S STATEMENT

TO BE COMPLETED BY PHYSICIAN OR SUPPLIER

PATIENT INFORMATION

1. PATIENT'S NAME:	2. RELATIONSHIP TO EMPLOYEE:	3. DATE OF BIRTH:
4. EMPLOYEE'S NAME:	5. EMPLOYEE'S SOC. SEC. NO.:	6. NAME OF EMPLOYER:
7. DOES PATIENT HAVE OTHER HEALTH COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, NAME OF OTHER INSURANCE CARRIER OR ADMINISTRATOR: _____		

PHYSICIAN'S OR SUPPLIER'S INFORMATION

8. DATE OF ILLNESS _____ (FIRST SYMPTOM) INJURY _____ PREGNANCY (LMP) _____	9. DATE FIRST SEEN FOR THIS CONDITION:	10. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? <input type="checkbox"/> YES <input type="checkbox"/> NO	11. WAS THIS AN EMERGENCY? <input type="checkbox"/> YES <input type="checkbox"/> NO
12. DATES OF TOTAL DISABILITY: FROM _____ THROUGH _____	13. DATE PATIENT ABLE TO RETURN TO WORK:	14. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? <input type="checkbox"/> YES <input type="checkbox"/> NO CHARGES _____	
15. NAME OF REFERRING PHYSICIAN:	16. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN HOME OR OFFICE):		
17. HOSPITAL ADMISSION DATE:	18. HOSPITAL DISCHARGE DATE:		

19. PRE-ADMISSION TESTING (IF APPLICABLE):

a) WERE ROUTINE ADMISSION TESTS PERFORMED OUT OF A HOSPITAL? YES NO

b) IF NO, COULD ROUTINE ADMISSION TEST HAVE BEEN PERFORMED OUT OF HOSPITAL? YES NO

IF NO, EXPLAIN WHY: _____

20. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (PLEASE INDICATE PRIMARY AND SECONDARY DIAGNOSIS):

1. _____	3. _____
2. _____	4. _____

21.		PROCEDURES, MEDICAL SERVICES, SUPPLIES FURNISHED					IDC-9 CM DIAGNOSIS CODE††	ADMINISTRATIVE USE ONLY
		DATE OF SERVICE	PLACE OF SERVICE*	CPT4 PROCEDURE CODE**	DESCRIPTION OF SERVICE	TYPE OF SERVICE***		

22. PHYSICIAN OR SUPPLIER: NAME (Please Print) _____ SIGNATURE _____ DATE _____	23. ENTER THE TAXPAYER IDENTIFYING NUMBER TO BE USED FOR 1099 REPORTING PURPOSES. YOU ARE REQUIRED UNDER AUTHORITY OF LAW TO FURNISH YOUR TAXPAYER IDENTIFYING NUMBER:	24. TOTAL CHARGE	25. AMOUNT PAID	26. BALANCE DUE
27. YOUR PATIENT'S ACCOUNT NO.		28. PHYSICIAN'S OR SUPPLIER'S ADDRESS, ZIP CODE & TELEPHONE NO. (IS THIS A NEW ADDRESS?) <input type="checkbox"/> YES <input type="checkbox"/> NO		

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| <p>*PLACE OF SERVICE CODES</p> <ul style="list-style-type: none"> 1 - (H) - Inpatient Hospital 2 - (OH) - Outpatient Hospital 3 - (O) - Doctor's Office 4 - (H) - Patient's Office 5 - Day Care Facility (PSY) 6 - Night Care Facility (PSY) 7 - (NH) - Nursing Home | <ul style="list-style-type: none"> 8 - (SNF) - Skilled Nursing Facility 9 - Ambulance 0 - (OL) - Other Locations A - (IL) - Independent Laboratory B - Other Medical Surgical Facility C - (RTC) - Residential Treatment Center D - (STF) - Specialized Treatment Facility | <p>***TYPE OF SERVICE CODES:</p> <ul style="list-style-type: none"> 1 - Medical Care 2 - Surgery 3 - Consultation 4 - Diagnostic X-Ray 5 - Diagnostic Laboratory 6 - Radiation Therapy 7 - Anesthesia | <ul style="list-style-type: none"> 8 - Assistance at Surgery 9 - Other Medical Services 0 - Blood or Packed Red Cells A - Used DME M - Alternate Payment for Maintenance Dialysis Y - Second Opinion on Elective Surgery Z - Third Opinion on Elective Surgery |
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