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# ATTENDING PHYSICIAN'S STATEMENT - HEALTH INSURANCE CLAIM

SPORT PEI – Policy # 6300005

| PATIENT'S NAME AND ADDRESS | AGE |
|---|---|
| | |

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|---|---|---|
| **1 A** | Diagnosis and Concurrent Conditions<br>(If fracture or dislocation, describe nature and location) | |
| **B** | Is condition due to injury or sickness<br>arising out of patient's employment? If "Yes" explain | Yes ☐ No ☐ |
| **2 A** | When did symptoms first appear or accident happen? | Date _____ Year: _____ |
| **B** | When did patient first consult you for this condition? | Date _____ Year: _____ |
| **C** | Has patient ever had same<br>Or similar condition? If "Yes" state when and describe | Yes ☐ No ☐ |
| **3 A** | Nature of surgical or obstetrical procedure,<br>If any (describe fully) | Date performed _____ Year: _____ |
| **B** | Charge to patient for this procedure including post-operative care | $ _____ |
| **C** | If performed in hospital, give name of hospital | _____ Inpatient ☐ Outpatient ☐ |
| **4** | Give dates of other medical (non-surgical) treatment, if any | Office _____<br>Home _____<br>Hospital _____<br>Nursing Home _____ |
| **5** | What other services, if any, did you provide patient?<br>(Itemize, giving dates and fees) | |
| **6** | Where registered private duty nurse (R.N.)<br>Services necessary? | |
| **7** | Is patient still under your care for this condition?<br>If "No" give date your services terminated | Yes ☐ No ☐ Date _____ Year: _____ |
| **8 A** | How long was or will patient be continuously totally disabled?<br>(Unable to work?) | From _____ Year:____ Thru _____ Year:____ |
| **B** | How long was or will patient be partially disabled? | From _____ Year:____ Thru _____ Year:____ |
| **C** | Was house confinement necessary? If "Yes" give dates | Yes ☐ No ☐ From _____ Year:____ Thru _____ Year:____ |
| **9** | To your knowledge, does patient have other health insurance or<br>Health plan coverages? If "Yes" identify | Yes ☐ No ☐ |

## REMARKS

| DATE | SIGNATURE (ATTENDING PHYSICIAN) | DEGREE | TELEPHONE |
|---|---|---|---|
| | | | |
| **STREET ADDRESS** | **CITY OR TOWN** | **PROVINCE** | **POSTAL CODE** |
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