



PROVIDENT AMERICAN

I N S U R A N C E

ACCIDENT INJURY - PHYSICIAN'S STATEMENT

Failure to complete this form in its entirety may result in a delay in processing this claim.

PATIENT'S NAME _____ POLICY NUMBER _____

PHYSICIAN'S STATEMENT Please answer each question COMPLETELY.

PHYSICIAN'S NAME

PHONE NUMBER

FAX NUMBER

ADDRESS

CITY

STATE

ZIP

DATES OF SERVICE	DIAGNOSIS CODE ICD	DIAGNOSIS DESCRIPTION	PROCEDURE CODE	PROCEDURE DESCRIPTION

Date of injury _____ Describe where and how the accident occurred: _____

Was patient hospitalized as a result of this diagnosis? Yes No Admission date: _____ Discharge date: _____

Hospital Name: _____ City: _____ State: _____

PHYSICIAN'S SIGNATURE

PRINT PHYSICIAN'S NAME

DATE

TAX ID NUMBER

ATTENTION PHYSICIAN: If patient is disabled, please ALSO complete the section below.

PHYSICIAN'S STATEMENT OF DISABILITY (MUST BE COMPLETED BY PHYSICIAN OR MEMBER OF PHYSICIAN'S STAFF)

1. First date of disability: _____ Last date of treatment: _____
2. Is patient currently working: full-time part-time light duty Date patient was released to return to work; _____
3. If patient has not been released to return to work or if patient is working light duty, please provide the next scheduled appointment date: _____
4. If patient is not employed or employed or working less than 30 hours, which Activities or Daily Living (ADLs) is the patient _____

PHYSICIAN'S SIGNATURE

PRINT PHYSICIAN'S NAME

DATE

TAX ID NUMBER

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is subject to criminal and civil penalties.

MAIL TO
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