PROVIDENT AMERICAN
INSURANCE

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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