PROVIDENT AMERICAN
INSURANCE

SICKNESS - 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

Symptoms first occurred on: _____ If diagnosed with cancer, date of initial diagnosis: _____
Patient first consulted you for this condition on: _____

Is there a referring physician? ☐ Yes ☐ No If yes, physician's name _____
Referring physician's address: _____Phone number: _____

Was patient hospitalized as a result of this diagnosis? ☐ Yes ☐ No Admission date _____ Discharge date _____
Hospital name and address: _____

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 unable to perform? ☐ Continence ☐ Transferring ☐ Dressing ☐ Toileting ☐ Eating ☐ Bathing

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
PROVIDENT AMERICAN INSURANCE COMPANY
10501 NORTH CENTRAL EXPRESSWAY, SUITE 200
Dallas, TX 75231
PHONE: 800.933.9456 OR 214.696.9091 FAX: 214.237.8664