FOR PHYSICIAN USE ONLY
ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S NAME	PATIENT'S BIRTH DATE

1. Diagnosis and Concurrent conditions (USE ID-9 CODE)*

2. Is Condition Due to Injury or Sickness Arising out of Patient's Employment? ☐ Yes ☐ No

Pregnancy? ☐ Yes ☐ No (If yes, approximate date pregnancy commenced) Date

3. Report of services (or attach itemized bill) (if previous form was submitted to Self-Funded Plans, Inc. you need only show dates and services since last report)

Date of Service	Place of Services †	Description of Surgical or Medical Services Rendered	CPT** Code	Charges

†O – Doctor's Office IH – Inpatient Hospital NH – Nursing Home
H – Patient's Home OH – Outpatient Hospital OL – Other Locations
*ICD-9 – International Classification of Diseases
**CPT – Current Procedural Terminology (current edition)

Total Charges - $_____
Amount Paid - $_____
Balance Due - $_____

4. Date Symptoms First Appeared or Accident Happened	5. Date Patient First Consulted You for this Condition
6. Has Patient Ever had the Same or Similar Condition? ☐ Yes ☐ No (If "Yes", when and describe)	7. Is Patient Still Under Your Care for this Condition? ☐ Yes ☐ No
8. Patient Was Continuously totally Disabled (unable to work) From Thru	9. Patient Was Partially Disabled From Thru
10. If Still Disabled, Date Patient Should Be Able to Return to Work	11. Patient was Hospital Confined From Thru

12. Does patient Have Other Health Coverage? (if "Yes", please identify) ☐ Yes ☐ No

13. Name and Address of Referring Physician

Date	Physician's Name (print)	Signature	Degree	Soc. Sec. No./T.I.N.	Telephone

Street Address	City or Town	State or Province	ZIP Code