LIFE INSURANCE COMPANY OF ALABAMA
P.O. BOX 349, GADSDEN, AL 35902

ATTENDING PHYSICIAN STATEMENT

Please have the attending **physician** complete and sign the form below and return it to us with an **itemized** statement of expenses. **Accident Claims Only**: If treatment is received in a Hospital Emergency Room, include a copy of the ER Records with the claim form and itemized bill. ***All QUESTIONS MUST BE ANSWERED BY THE ATTENDING PHYSICIAN.*** **Disability benefits are approved only through the date the attending physician signs the form.** We reserve the right to request additional information to verify the claimant's condition or period of disability. **Cancer Claims enclose a Pathology Report. For Dread Disease Claims enclose Cytology or other lab reports diagnosing the condition.**

PATIENT'S NAME: _____ AGE: _____

DATE OF BIRTH: _____-_____-_____ RELATIONSHIP TO INSURED: ❑ SELF ❑SPOUSE ❑ CHILD ❑ OTHER

DIAGNOSIS: _____

ICD CODE(S): PRIMARY_____ SECONDARY: _____ _____ _____ _____

PROCEDURE(S) PERFORMED: _____

CPT CODE(S): _____ _____ _____ _____ _____

DATES OF SERVICE _____-_____-_____ / _____-_____-_____ / _____-_____-_____

IF HOSPITALIZED: DATE ADMITTED: _____-_____-_____ DATE DISCHARGED: _____-_____-_____

❑ INPATIENT ❑ OUTPATIENT

NAME & ADDRESS OF HOSPITAL: _____

_____

_____

IS THE PATIENT'S CONDITION DUE TO: ACCIDENT? _____ SICKNESS? _____ PREGNANCY? _____

WHEN DID SYMPTOMS FIRST APPEAR? _____

WHEN DID ACCIDENT HAPPEN? _____

DID THE ACCIDENT HAPPEN WHILE WORKING ON-THE-JOB? ❑ YES ❑ NO

WHEN DID PATIENT **FIRST** CONSULT YOU FOR THIS CONDITION? _____

HAS PATIENT EVER HAD THIS SAME OR SIMILAR CONDITION? ❑ YES ❑ NO IF "YES" STATE WHEN AND DESCRIBE:

_____

DESCRIBE ANY OTHER DISEASE OR CONDITION AFFECTING PRESENT CONDITION: _____

_____

NAME AND ADDRESS OF REFERRED/REFERRING PHYSICIAN: _____

_____

IF PATIENT IS TOTALLY DISABLED, PLEASE COMPLETE THIS SECTION

WHAT ARE THE PATIENT'S PRESENT LIMITATIONS? _____

WHAT IS THE PRIMARY CONDITION THAT HAS RENDERED THE PATIENT TOTALLY DISABLED?

_____

HOW LONG HAS THE PATIENT BEEN CONTINUOUSLY TOTALLY DISABLED? From: _____

To: _____

IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? ❑ YES ❑ NO DISCHARGE DATE: _____-_____-_____

PHYSICIAN'S NAME (PLEASE PRINT): _____

ADDRESS: _____

PHONE: (_____)_____-_____ SSN OR TAX ID NO: _____-_____-_____

DATE: _____-_____-_____ PHYSICIAN'S SIGNATURE: _____