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

ATTENDING PHYSICIAN'S STATEMENT

ALL QUESTIONS MUST BE ANSWERED BY THE ATTENDING PHYSICIAN

Please complete and sign the form below and return it to us with an itemized statement of expenses. **Accident Claims**: If treatment is received in a Hospital Emergency Room, include a copy of the ER Records with the claim form and an itemized statement of patient's account showing CPT(current procedural terminology), procedure codes, billed amounts, payments, and credits to the account. ***DISABILITY BENEFITS ARE APPROVED ONLY THROUGHT 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 along with an itemized statement of patient's account showing CPT(current procedural terminology) procedure codes, billed amounts, payments, and credits to the account for the treatment of cancer. **Dread Disease Claims:** Enclose Cytology and/or other laboratory, imaging reports or diagnostic testing diagnosing the condition.

PATIENT'S NAME _____ Date of Birth: _____-_____-_____

Diagnosis: _____

ICD Code(s): Primary _____ Secondary _____ _____ _____ _____ _____ _____

Procedure(s) performed: _____

CPT Code(s) performed: _____ _____ _____ _____ _____ _____ _____ _____

Dates of Service: _____-_____-_____ / _____-_____-_____ / _____-_____-_____

If Hospitalized: Date Admitted: _____-_____-_____ Date Discharged: _____-_____-_____

Inpatient☐ Outpatient☐

Name and Address of Hospital: _____

_____

_____

Name and Address of the referred/referring physician: _____

_____

_____

Is the patient's condition due to: Accident☐ Sickness☐ Pregnancy☐

When did the patient's symptoms first appear? _____

When was the patient first diagnosed with the sickness condition? _____

When did the patient first consult you for the sickness or accident condition? _____

When did the accident happen? _____

Did the accident happen while working on-the-job? Yes☐ No☐

Has the patient ever had the same or similar conditions? Yes☐ No☐ If "yes" state when and describe: _____

_____

Describe any other disease or condition affecting the patient's present condition: _____

_____

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 the patient still under your care for this condition? Yes☐ No☐ Discharge Date: _____-_____-_____

Physician's Name (Please Print): _____

Address: _____

Phone: (_____) _____ _____ SSN or Tax ID Number: _____-_____-_____

Date _____-_____-_____ Physician's Signature: _____