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

PHYSICIAN'S STATEMENT FOR KIDNEY - TRANSPLANT

ALL QUESTIONS MUST BE ANSWERED BY THE PHYSICIAN

Please complete the Physician's Statement answering all questions and return to our office along with a copy of the following:

(1) CT scan, MRI or similar imaging diagnosing Kidney Failure.
(2) Clinical evidence of Kidney Failure.
(3) Results of lab testing (biopsy, urine tests, blood tests) which indicate Kidney Failure.
(4) Operative Report for the Kidney Transplant

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: ______________________

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Name and Address of the referred/referring physician: ______________________

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When did symptoms first appear? ______________________

When did the patient first consult you for this condition? ______________________

Has the patient ever had this same or similar condition? ☐Yes ☐No

Did the patient positively incur Kidney Failure or Major Organ Failure? ☐Yes ☐No

Was Kidney Failure or Major Organ Failure confirmed with a CT scan, MRI, or similar imaging technique? ☐Yes ☐No

Was there clinical evidence of Kidney Failure or Major Organ Failure? ☐Yes ☐No

Has the patient been diagnosed with Kidney Failure or Major Organ Failure prior to the current condition? ☐Yes ☐No

If yes, when? __________-__________-__________

Is the patient currently receiving or has the patient ever received Kidney or Peritoneal Dialysis? ☐Yes ☐No

If yes, when? __________-__________-__________

Did the patient undergo a Kidney Transplant or another Major Organ Transplant? ☐Yes ☐No

If yes, when? __________-__________-__________

If yes, what Major Organ was transplanted? ______________________

Describe any other disease or condition affecting the present condition: ______________________

Physician's Name (Please Print): ______________________

Address: ______________________

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

Date __________-__________-__________ Physician's Signature: ______________________