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

PHYSICIAN'S STATEMENT

ALL QUESTIONS MUST BE ANSWERED BY THE CARDIOLOGIST

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

(1) Cardiac Enzyme (CKMB, Troponin) test results
(2) EKG test results
(3) Operative Report (if heart surgery was performed)

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: _____

_____

_____

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

If yes, state when and describe: _____

_____

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

_____

Did your patient positively incur an Acute Myocardial Infarction? ☐Yes ☐No

Was Acute MI confirmed with significant abnormal electrocardiograph findings? ☐Yes ☐No

If yes, please provide the test results.

Was Acute MI confirmed with elevation of cardiac enzymes? ☐Yes ☐No

If yes, please provide the test results.

Was Acute MI caused by severe stenosis or narrowing of a coronary artery causing a partial occlusion? ☐Yes ☐No

If yes, what was the occlusion percentage of the lumen of the coronary artery? _____

Has the patient been diagnosed with a MI, heart disease or disorder of the heart or coronary arteries or any heart related condition prior to the current condition? ☐Yes ☐No

Has the patient been diagnosed with a Stroke or transient ischemic attack? ☐Yes ☐No

If yes, when? _____-_____-_____

Has the patient ever been diagnosed with any type of diabetes? ☐Yes ☐No

If yes, is the patient insulin dependent? ☐Yes ☐No

If yes, give date and details: _____-_____-_____ _____

_____

Physician's Name (Please Print): _____

Address: _____

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

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