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

PHYSICIAN'S STATEMENT

ALL QUESTIONS MUST BE ANSWERED BY THE NEUROLOGIST

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 the Stroke.
(2) Clinical evidence of infarction of brain tissue, or intracranial or subarachnoid hemorrhage.
(3) Results of the Modified Rankin Scale for Stroke Outcome.

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 a Stroke? ☐Yes ☐No

Was the Stroke confirmed with a CT scan, MRI or similar imaging technique? ☐Yes ☐No

Was there clinical evidence of infarction of brain tissue, or intracranial or subarachnoid hemorrhage? ☐Yes ☐No

Was there permanent neurological deficit measured 30 days or more after the event that resulted in a score of 2 or higher on the Modified Rankin Scale? ☐Yes ☐No

Has the patient been diagnosed with a Stroke prior to the current condition?
If yes, when? __________-__________-__________

Has the patient ever been diagnosed with a transient ischemic attack?
If yes, when? __________-__________-__________

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: ______________________________