Attending Physician's Statement

(Please print – Attach separate sheet if additional space required)

PATIENT INFORMATION

Patient's Name_____

Date of Birth____/____/____ (MM/DD/YY)

Patient's Address_____

Phone No. (Primary)_____ Phone No. (Secondary)_____

Insured's Name: _____ Patient's relationship to Insured: _____

Insured's Email Address: _____

Are you related by blood or marriage to the Insured? **YES NO**

CLAIM INFORMATION

Are you the patient's primary treating physician? **YES NO**

If not, please provide the name and address of primary treating physician:

_____

Date of accident/illness:____/____/____ (MM/DD/YY)

Date of first treatment:____/____/____ (MM/DD/YY)

Please describe in detail the nature of the Insured's injuries/illness, including all applicable ICD-10 codes:

_____

_____

_____

Was the patient hospitalized? **YES / NO**

If yes, please list the names and addresses of all hospitals and all admission/discharge dates:

Hospital Name	Address	Admission Date MM/DD/YYYY	Discharge Date MM/DD/YYYY

Did the patient's condition prevent them from traveling? **YES / NO**

If Yes, date the patient was unable to travel: ____/____/____ (MM/DD/YY)

Did the patient have any prior injury or illness that contributed to the patient's present condition? **YES / NO**

If yes, please describe:

Were any surgical procedures performed? **YES / NO**

If yes, please list all procedures, including applicable CPT codes and dates performed:

What are the patient's current subjective symptoms?

What are the objective findings? (please include results of current x-rays, lab tests, etc.,)?

Was the patient seen by any other physician? **YES / NO**

If yes, please list the names and addresses of all other physicians:

ATTENDING PHYSICIAN INFORMATION

Name of Attending Physician: _____

Phone No. (_____)_____

Address: _____

_____

_____

Specialty: _____

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Attending Physician) _____

DATE____/____/____ (MM/DD/YY)

***Mail the completed and signed form to:**
Claim Benefit Services P.O. Box 459084 Sunrise, FL 33345
Or *Fax to: 1-855-830-3728
***Please include a cover sheet or cover letter with Insured name, Claim # and physician contact information**
PLEASE NOTE: Any fees associated with the completion of this form and/or medical records requests remain the responsibility of the patient, insured or claimant. All invoices or requests for payment sent to Broadspire will be returned to sender.