

PART A TO BE COMPLETED BY PATIENT (INSURED)

PATIENT'S NAME AND ADDRESS

INSURED'S NAME AND ADDRESS IF PATIENT IS A DEPENDENT

AUTHORIZATION TO RELEASE INFORMATION: I HEREBY AUTHORIZE
THE UNDERSIGNED PHYSICIAN TO RELEASE ANY INFORMATION
ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT.

SIGNED (PATIENT, OR PARENT IF MINOR)

DATE

PART B ATTENDING PHYSICIAN'S STATEMENT

For routine FIRST-AID claims, this side is not usually required, if a copy of the bill showing Patient's name, diagnosis, charges, and date incurred is
furnished along with Claimant's Statement on reverse side.

1. DIAGNOSIS AND CONCURRENT CONDITIONS

(IF DIAGNOSIS CODE OTHER THAN ICDA USED, GIVE NAME)

2. IS CONDITION DUE TO INJURY OR SICKNESS ARISING
OUT OF PATIENT'S EMPLOYMENT? YES NO

3. IF CONDITION IS DUE TO ACCIDENT, PLEASE GIVE DETAILS OF
ACCIDENT.

4. IS CONDITION DUE TO PREGNANCY? YES NO

IF YES, EXPECTED DATE OF DELIVERY

DATE OF LMP

5. REPORT OF SERVICES (OR ATTACH ITEMIZED BILL). IF A PREVIOUS FORM HAS BEEN SUBMITTED TO THIS CARRIER, YOU
NEED SHOW ONLY DATES AND SERVICES SINCE LAST REPORT.

Date of
Services
(Mo. Day, Yr.)

Place of
Services

Description of Surgical or Medical Services Rendered

Procedure Code –
If used (If code other
than CPT used, give name)