

SECTION C

ATTENDING PHYSICIAN'S STATEMENT

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

NOTE: RETURN COMPLETED FORM TO THE EMPLOYEE

TYPE OR PRINT

MEDICARE

MEDICAID

CHAMPUS

OTHER

PATIENT & EMPLOYEE INFORMATION

1. PATIENT'S NAME (First name, middle initial, last name)	2. PATIENT'S DATE OF BIRTH / /	3. EMPLOYEE'S NAME (First name, middle initial, last name)
4. PATIENT'S ADDRESS (Street, city, state, ZIP code)	5. PATIENT'S SEX <input type="checkbox"/> M <input type="checkbox"/> F	6. EMPLOYEE'S SS# or MEDICARE NO. (Include any letters)
	7. PATIENT'S RELATIONSHIP TO EMPLOYEE <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER	8. EMPLOYEE'S GROUP NO. 141350
9. OTHER HEALTH INSURANCE COVERAGE – Enter name of Policy-holder and Plan Name and Address and Policy or Medical Assistance Number.	10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT <input type="checkbox"/> YES <input type="checkbox"/> NO B. AN AUTO ACCIDENT <input type="checkbox"/> YES <input type="checkbox"/> NO	11. EMPLOYEE'S ADDRESS (Street, city, state, ZIP code)
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Read Section A, Authorization, before signing.) I authorize the release of any medical information necessary to process this claim.		13. I authorize payment of Medical Benefits to undersigned, physician or supplier for services described below.
SIGNATURE _____	DATE _____	SIGNATURE (Employee or Authorized Person) _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION	16. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? <input type="checkbox"/> YES <input type="checkbox"/> NO
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____		DATES OF PARTIAL DISABILITY FROM _____ THROUGH _____
19. NAME OF REFERRING PHYSICIAN		20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____	
21. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)		22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? <input type="checkbox"/> YES <input type="checkbox"/> NO CHARGES:	

23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY, RELATE DIAGNOSIS TO PROCEDURE IN COLUMN D BY REFERENCE TO NUMBERS 1, 2, 3, ETC. OR DX CODE

1. _____

2. _____

3. _____

4. _____

24. A DATE OF SERVICE	B* Place of Service	C FULLY DESCRIBE PROCEDURE, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN. PROCEDURE CODE (Identify) (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D Diagnosis	E CHARGES	F

25. Signature & Certification of Physician or Supplier: (I certify that the number shown on this form is my correct taxpayer identification number and I am not subject to backup withholding.)	26. ACCEPT ASSIGNMENTS (Government claims only) <input type="checkbox"/> YES <input type="checkbox"/> NO	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
SIGNATURE _____ DATE _____	30. YOUR SOCIAL SECURITY NO.	31. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NO.		
32. YOUR PATIENT'S ACCOUNT NO.	33. YOUR EMPLOYER I.D. NO.	I.D. NO.		

*PLACE OF SERVICE CODES

1 — (IH) — INPATIENT HOSPITAL	4 — (H) — PATIENT'S HOME	7 — (NH) — NURSING HOME	0 — (OL) — OTHER LOCATIONS
2 — (OH) — OUTPATIENT HOSPITAL	5 — DAY CARE FACILITY (PSY)	8 — (SNF) — SKILLED NURSING FACILITY	A — (IL) — INDEPENDENT LABORATORY
3 — (O) — DOCTOR'S OFFICE	6 — NIGHT CARE FACILITY (PSY)	9 — AMBULANCE	B — OTHER MEDICAL/SURGICAL FACILITY
			C — EMERGENCY ROOM

APPROVED BY AMA COUNCIL ON MEDICAL SERVICES 6-74