ATTENDING PHYSICIAN'S STATEMENT

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 ☐ Pregnancy? (If "Yes", Approximate Date Commenced) Yes ☐ No ☐

3. Report Of Service (Or Attach Itemized Bill) (If Previous Form Submitted To This Carrier, You Need Show Only Dates and Services Since Last Report)

Date of Service	Place of Service	Description of Surgical or Medical Services Rendered	Procedure Code CPT	Charges

Total Charges $

Amount Paid $

Balance Due $

4	5. Date Patient First Consulted You For This Condition
6	7
8. Patient Was Continusly Totally Disabled	9
10. If Still Disabled Date Patient Should Be Able To Return To Work	11

12. Does Patient Have Other Health Coverage?

YES ☐ NO ☐ (If "Yes" Identify)

Date	Physician's Name(Print)	Signature	Social Security Number	Telephone

Street Address	City	State	Zip code

Other Comments