ATTENDING PHYSICIAN STATEMENT

Fax this form: 1-972-726-6028 or mail to P.O. Box 809043, Dallas, TX 75380

Email: Claims@nfclife.com

Select

Patient's Name: _____ Date of Birth: _____

Street: _____ Phone Number: _____

City: _____ State: _____ Zip: _____

PRIMARY DIAGNOSIS? (Must include ICD-9 Code)

Date of Accident**?** (If applicable)

Date patient first consulted you for this condition?

Date patient first noted symptoms before consulting you?

List medications patient has taken for this condition in past 2 years.

Has patient received consultation or treatment for this condition in the past year?

Has patient ever had same or similar

condition? Yes ☐ No ☐.

If Yes, when and describe.

Please describe the pain (character, location, etc.) and the associated symptoms and findings (shock, dyspnea, arrythmia, failure, etc.).

What special studies were made (ECG, X-ray, etc.)? When? What were the results?

Date(s) of Hospital Admission and Discharge?

From _____ To _____
From _____ To _____
From _____ To _____
From _____ To _____

Is any medication being taken (digitalis, anti-coagulants, coronary dilator drugs, etc.)?

Yes ☐ No ☐ If Yes, please supply type and dosage.

Date: _____ Physicians Name: _____ Degree: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Physician's Signature: _____

Clear Form