

ATTENDING PHYSICIAN'S STATEMENT

**PLEASE COMPLETE THIS FORM
IN FULL FOR PROMPT SERVICE.**



Please Complete and Mail To:

VFIS
P.O. Box 5126, York, Pennsylvania 17405-9726
Call (717) 741-0911 · Toll Free: (800) 233-1957
Fax # (717) 747-7051

NOTE: IMPORTANT STATE INFORMATION
ON REVERSE SIDE

Name of Patient _____ Age _____
Address _____ Telephone _____
Regular Occupation _____
Name of Insured Organization _____ Policy No. _____

IMPORTANT

Have Insured Member (Patient) sign following Authorization

I hereby authorize any hospital, physician, or other person who has attended me or examined me to furnish to VFIS, Inc., any and all information with respect to any accident or illness, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature _____
Insured Member Patient

PART B – TO BE COMPLETED BY ATTENDING PHYSICIAN

Dear Doctor:

The above named individual has filed a claim for benefits as a result of the Accident/Sickness for which he is currently or has been under your care. In order that we might give his claim proper attention, would you kindly answer the following questions at your earliest convenience and forward completed form to us. ****The Company does not assume any expense incidental to the completion of this form.***

(1) Diagnosis and Concurrent Conditions
(If Fracture or Dislocation, Describe Nature and Location,
If Sickness Describe Nature)

(2A) When Did Symptoms First Appear or Accident Happen? Date _____ Year _____

(B) When Did Patient Consult You For This Condition? Date _____ Year _____

(C) Has Patient Ever Had Same or Similar Condition? (If Yes, State When and Describe) Yes _____ No _____ Year _____

(3A) Nature of Surgical Procedure, If Any (Describe Fully)- Date Performed _____ Year _____

(B) If Performed in Hospital, Give Name and Address - Inpatient _____ Outpatient _____

(4) What other Services, If Any, Did You Provide Patient?

(5) Is Patient Still Under Your Care For This Condition? Yes _____ No _____
If "No" Give Date Your Services Terminated. Date _____

(6A) How Long Was or Will Patient Be Continuously Totally Disabled (**Unable To perform Regular Occupation**) Due to Diagnosis in #1 Above? From _____ Year _____ Thru _____ Year _____

(B) How Long Was or Will Patient Be Partially Disabled? From _____ Year _____ Thru _____ Year _____

(C) Approximate Date Patient Will Return To Work If Still Disabled. _____ Year _____

Date _____ Signature _____

Street Address _____ City or Town _____ (attending physician) _____ (degree) _____ (telephone no.) _____
State or Providence _____ Zip Code _____