# ATTENDING PHYSICIAN'S STATEMENT

**PLEASE COMPLETE THIS FORM IN F''.L FOR PROMPT SERVICE.**

Please Complete and Mail To:

VFIS of Texas
3420 Executive Center Drive, Suite 301
Austin, TX 78731-1626
Phone (800) 252-9435 Fax (512) 448-9929

"Any person who knowingly and with intent to defraud any insuran company or other person files a statement of claim containing any materially false information, or concealed for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime."

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 ______

(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 ______ ______ Year

(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 ______
(attending physician) (degree) (telephone no.)

Street Address ______ City or Town ______ State or Providence ______ Zip Code ______

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