IT IS UNLAWUFUL TO FILE A FALSE OR FRADULENT CLAIM

Part B

ATTENDING PHYSICIAN'S STATEMENT

THIS FORM MUST BE COMPLETED & SIGNED BY THE ATTENDING PHYSICIAN/PROVIDER ONLY

Patient's Name	Date of Birth

Date Patient Able to Return to Work	Date of Total Disability (Estimate if Not Known) From Through

Name & Address of Facility Where Services Rendered (If other than Home or Office)

Name: ____

Address: ____

____

Diagnosis or Nature of Illness or Injury Related Diagnosis to Procedure in Column by Reference to Number 1,2,3, ETC OR DX Code

1 ____

2 ____

3 ____

4 ____

I attest the information noted above is accurate and truthful based on information provided to me and upon my review and examination of the information and patient.

Attending Physician/Provider Signature________________________________ Date __________

Name: ______________________________ Facility: ______________________________

Address: ____

Phone: ______________________________ Fax: ______________________________

***PLEASE USE CURRENT PROCEDURAL TERMINOLOGY CODES FOR SURGERY**

21. (H) INPATIENT HOSPITAL	12. (HJ) PATIENTS HOME	32. (NH) NURSING HOME	0. (OL) • OTHER LOCATIONS
22. (OH) OUTPATIENT HOSPITAL	12. DAY CARE FACILITY (PSY)	31. (IL) SKILLED NURSING FACILITY	81. (IL) INDEPENDENT LABORATORY
11. (O) DOCTORS OFFICE	12. NIGHT CARE FACILITY (PSY)	41. AMBULANCE	B. OTHER MEDICAL/SURGICAL