Print Form

ATTENDING PHYSICIAN'S STATEMENT

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

PLEASE COMPLETE THIS FORM IN FULL FOR PROMPT SERVICE.

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? Yes ○ No ○
(If Yes, State When and Describe)

(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

Applicable in Pennsylvania

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material hereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Applicable in New York

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Applicable in California

For your protection, California law requires the following to appear in this form:
Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Applicable in all other states

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.