SUPPLEMENTAL PHYSICIAN'S STATEMENT TO BE COMPLETED BY TREATING PHYSICIAN

Patient's Name_____ Policy Number: _____

Cancer Claims:

1. When was **any** type of cancer first diagnosed? _____ Diagnosis code(s): _____

2. When did you first consult the most recent condition? _____

3. Is this a recurrence of a previous cancer? ❑ YES ❑ NO If YES, give date of recurrence: _____

List date of last known cancer treatment: _____ Type of treatment: _____

4. List name of referring physician: _____ Phone number: _____

5. Was patient hospitalized solely due to this condition? ❑ YES ❑ NO

If YES, list name & address of facility: _____

Date admitted: _____ Date discharged: _____

6. If outpatient, list dates of service: _____

7. What services were rendered during the period listed above?

❑ biopsy ❑ surgery ❑ chemotherapy ❑ radiation ❑ hospice ❑ skilled nursing

8. Please provide any applicable surgery CPT procedure code(s): _____

_____

9. Has the patient ever been diagnosed with AIDS/ARC? ❑ YES ❑ NO If YES, when? _____

Intensive Care Claims:

1. Has the patient **ever** been diagnosed with or treated for a heart attack, heart disease or stroke? ❑ YES ❑ NO

If YES, date of first diagnosis: _____ If YES, date of first treatment: _____

2. List reason for hospitalization: _____

3. Was the patient ever diagnosed with the above condition prior to this admission? ❑ YES ❑ NO

If YES, when? _____

4. Was patient hospitalized solely due to this condition? ❑ YES ❑ NO

If YES, list name & address of facility: _____

Date admitted: _____ Date discharged: _____

5. List specific dates of intensive care confinement: _____

6. Has the patient ever been diagnosed with AIDS/ARC? ❑ YES ❑ NO If YES, when? _____

Physician's Information:

Physician's Name: _____

Specialty: _____

Address and phone number: _____

Completed by (please print): _____ Position/Title: _____

Physician's Signature: _____ **Date:** _____