AMERICAN FIDELITY
a different opinion

Benefits Department | P.O. Box 25160 | Oklahoma City, OK 73125-0160
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Attending Physician Statement

To be completed by the physician.

Name of Patient:	Date of Birth: (MM/DD/YYYY)	Social Security Number:	Customer Number:

Diagnosis

Disabling Diagnoses:	ICD Code:

History

When did symptoms first appear or accident happen? (MM/DD/YY) Date patient first consulted you for this condition? (MM/DD/YY)

Has the patient ever had the same or similar condition? ☐ Yes ☐ No If yes, indicate when and describe:

Was the patient referred to you? ☐ Yes ☐ No If yes, provide full name, address, and phone number of referring physician:

Is the disability work related? ☐ Yes ☐ No

Treatment

Frequency of treatment: ☐ Monthly ☐ Weekly ☐ Other	If other, please describe:
Date of next appointment: (MM/DD/YY)	Please describe current treatment:

List all dates of treatment or medical attention since the disability began:

Is patient still under your regular care for this condition? ☐ Yes ☐ No	If no, please explain and provide name and phone number of the current treating physician:

Has the patient been confined to a hospital? ☐ Yes ☐ No If yes, give admit and discharge dates along with name and address of hospital.	Admitted: (MM/DD/YY) Discharged: (MM/DD/YY) Admitted: (MM/DD/YY) Discharged: (MM/DD/YY)
Name:	Address:

Prognosis

Is patient now Disabled? For Regular occupation? ☐ Yes ☐ No	For any Occupation? ☐ Yes ☐ No
Date total disability began: (MM/DD/YY)	What is the expected return to work date? (MM/DD/YY)

Is the patient released to return to work with restrictions? ☐ Yes ☐ No If yes, From: (MM/DD/YY) Through: (MM/DD/YY)
Please list return to work restrictions:

Anticipated length of disability: ☐ 1-2 Months ☐ 2-3 Months ☐ 3-6 Months ☐ 6-12 Months ☐ Greater than 12 Months ☐ Permanent

Impairments

Please list functional limitations/restrictions that render your patient temporarily totally disabled:

Do you expect any improvement or decline in functional status? ☐ Yes ☐ No If yes, please select ☐ improvement OR ☐ decline

Physician Information

Attending Physician's Name & Title: (print) Specialty:

Phone: (with area code) Fax: (with area code)

Mailing Address: (street, city, state, zip)

Form Completed By: (Name & Title) Signature: Date: (MM/DD/YY)

If you require completion of your own authorization for the release of medical records please submit the form along with the physician statement.