Emergency Services Insurance Program
McNeil & Company, Inc.
P.O. Box 5670, Cortland, New York 13045

HEALTH CARE PROVIDER'S STATEMENT

THE TOP PORTION TO BE COMPLETED AND SIGNED BY THE MEMBER PRESENTING THE CLAIM

Date _____

Patient's Name _____

Address _____ Telephone (_____) _____

Name of Emergency Service Organization _____

Address _____

Certificate Number _____

I authorize any Health Care Provider, Insurance Company, Employer, Person or Organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability or employment related information to McNeil & Company, Inc./ Emergency Services Insurance Program or their employees and authorized agents for the purpose of validating and determining benefits payable. This data may be extracted for use in audit or statistical purposes. I understand that I or my authorized representative will receive a copy of the authorization request. This authorization or a photocopy of the original shall be valid for the duration of the claim.

X _____ _____
Patient's / Claimant's Signature Date

PARTS A. THROUGH H. TO BE COMPLETED AND SIGNED BY THE HEALTH CARE PROVIDER

THE COMPANY DOES NOT ASSUME ANY EXPENSE INCIDENTAL TO THE COMPLETION OF THIS FORM.

A. Present Condition _____
Diagnosis

_____
Subject Symptoms

_____
Objective Findings (X-Rays, E.K.G.'s, Laboratory Data and Clinical Findings)

_____ Date of last visit _____

When did symptoms first appear or accident happen? _____

Has the patient ever had the same or similar condition? _____ If so when? _____

Describe _____

Nature of surgical procedure if any (please describe in full) _____

B. Limitation (If there is a limitation, please check and describe below)

Standing ☐ Climbing ☐ Bending ☐ Use of Hands ☐ Sitting ☐
Walking ☐ Stooping ☐ Lifting ☐ Psychological ☐ Other ☐ _____

C. Progress

Has Patient Recovered? ☐ Improved? ☐ Unchanged? ☐ Retrogressed? ☐
Is Patient Bed Confined? ☐ Hospital Confined? ☐ Ambulatory? ☐ House Confined? ☐

Has Patient been Hospital confined? ☐ Yes ☐ No If Yes, give name and address of Hospital _____

_____ Confined from _____ Through _____

D. Cardiac (If Applicable)

Functional Capacity (American Heart Assoc.) Class 1 (No Limitation) ☐ Class 2 (Slight Limitation) ☐ Class 3 (Marked Limitation) ☐ Class 4 (Complete Limitation) ☐

Remarks _____

Blood Pressure (last visit) _____ _____
Systolic Diastolic

THE HEALTH CARE PROVIDER MUST COMPLETE AND SIGN PAGE (2) OF THIS FORM.
A COPY OF THE PATIENT'S CHART MAY BE ATTACHED AS A SUPPLEMENT TO THIS FORM

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E. Extent of Disability

How long was or will Patient be Continuously Totally Disabled From _____ Through _____
(Unable to perform his or her regular occupation due to diagnosis on the previous page)

How long was or will the Patient be Partially Disabled From _____ Through _____

Approximate date that the Patient will return to work if still disabled _____

F. Mental / Nervous Impairment (If Applicable)

Please define "stress" as it applies to this claimant.

- ☐ Class 1 – Patient is able to function under stress and engage in interpersonal relationships (no limitations)
- ☐ Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
- ☐ Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
- ☐ Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
- ☐ Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

G. Rehabilitation

Is the Patient a suitable candidate for rehabilitation? ☐ Yes ☐ No

Is the patient capable of working at another occupation? If so, please describe _____

H. Remarks _____

Health Care Provider's Name (Please Print) _____

Address _____

Telephone _____ Federal Tax I.D. Number _____

Signature _____ Date _____