McNeil&Co.

WILSON GREGORY
CLAIM FORM
ATTENDING PHYSICIAN'S STATEMENT FORM

P.O. Box 5670
Cortland, NY 13045
Phone: (800) 822-3747
Fax: (607) 756-5051
Email: loss_notice@
mcneilandcompany.com

Part Four – Attending Physician's Statement – Must be completed by the attending Physician

HEALTH INSURANCE CLAIM FORM

READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM

Type of Coverage: ☐ MEDICARE ☐ MEDICAID ☐ CHAMPUS ☐ OTHER _____

PATIENT & INSURED (SUBSCRIBER INFORMATION)

PAITIENT'S NAME: (First name, Middle Init, Last name)	PATIENT'S DATE OF BIRTH

PAITIENT'S ADDRESS: Street, City, State, ZIP code)

WAS CONDITION RELATED TO A) PATIENT'S EMPLOYMENT ☐ Yes ☐ No B) AN AUTO ACCIDENT ☐ Yes ☐ No	

PAITIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Read back before signing)
and I Authorize Payment of Medical Benefits to the Undersigned Physician or Supplier for services described below.

SIGNED DATE

PHYSICIAN OR SUPPLIER INFORMATION

DATE OF INJURY ACCIDENT	DATE FIRST CONSULTED YOU FOR THIS CONDITION	HAS THE PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? ☐ Yes ☐ No
DATE PATIENT ABLE TO RETURN TO WORK	DATES OF TOTAL DISABILITY FROM THROUGH	DATES OF PARTIAL DISABILITY FROM THROUGH
		FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED DISCHARGED

DIAGNOSIS OR NATURE OF INJURY

1.
2.
3.
4.

SIGNATURE OF PHYSICIAN OR SUPPLIER (Read back before signing) SIGNED DATE	
YOUR PATIENT'S ACCOUNT NO.	