Emergency Services Insu
McNeil & Company, Ir
P.O. Box 5670, Cortland, Ne

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

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 VIOLATION.

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	☐ ______________

THE HEALTH CARE PROVIDER MUST COMPLETE AND SIGN PARTS A. THROUGH H. OF THIS FORM.
A COPY OF THE PATIENT'S CHART MAY BE ATTACHED AS A SUPPLEMENT TO THIS FORM

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

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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 Class 1 (No Limitation) ☐ Class 2 (Slight Limitation) ☐
(American Heart Assoc.) Class 3 (Marked Limitation) ☐ Class 4 (Complete Limitation) ☐
Remarks ____
Blood Pressure (last visit) ____________________ ____________________
Systolic Diastolic

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 ______________________________

____

____

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H. Remarks ____
____
____
____
____

Health Care Provider's Name (Please Print) ______________________________

Address ____
____

Telephone ______________________ Federal Tax I.D. Number ______________________

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Signature ______________________________ Date ______________