Health Care Provider's Statement
(If missing time from regular occupation)

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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 ____________

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

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

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 From __________ Through __________

Approximate date that the Patient will return to work (regular occupation) 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 ______________

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