SECTION D – ATTENDING PHYSICIAN'S STATEMENT

The patient is responsible for the completion of this form without expense to the Claims Administrator.

FAX forms to: **518-640-8105** or EMAIL to: **CLAIMS@PEARLINSURANCE.COM**
or MAIL to: PEARL INSURANCE – CLAIMS DEPARTMENT, 13 AIRLINE DR, ALBANY, NY 12205

NOTICE TO PROVIDER: Thank you in advance for your cooperation in completing this form on behalf of your patient identified below. We will consider this information in conjunction with other information gathered to determine the claimant's eligibility for benefits according to his or her specific contract with us. We will periodically request that you provide updated information, records and chart notes to enable our evaluation of a continuing claim. **In order for us to expedite our consideration of your patient's claim, please fully answer each question and sign and date the form where indicated.**

Patient Name (Last, First, MI)		Date of Birth	Social Security Number XXX - XX -
Policy Owner (if other than Patient)	Name (Last, First, MI)		Social Security Number XXX - XX -

Primary Diagnosis: _____ ICD-10 CM Code: _____

Secondary Diagnosis: _____ ICD-10 CM Code: _____

Date that symptoms first appeared or accident happened: _____

Date that patient first consulted you for this condition? _____ Date you last treated the patient: _____

Is this condition related to patient's employment? ☐ Yes ☐ No

Was patient referred to you by another practitioner? ☐ Yes ☐ No If yes, provide the name and address of practitioner:

Objective Findings (Include x-rays, lab results and clinical findings. If pregnancy, also provide LMP and EDC):

Has patient been hospitalized for this condition? ☐ Yes ☐ No If yes, provide reason, hospital name and dates of confinement:

Nature of treatment currently being provided or planned (Include dates and type of surgery and any medications prescribed):

Has patient been treated for same or similar condition prior to this occurrence? ☐ Yes ☐ No If yes, provide details and date(s):

Patient Name (Last, First, MI) | Social Security Number XXX - XX -

Have you referred patient to another practitioner? ☐ Yes ☐ No If yes, provide the name and address of practitioner(s):

In your opinion, is patient able to work at this time? ☐ Yes ☐ No

If no, when do you expect that the patient will be able to perform some work? _____

Is there any type of job modification or accommodation that would enable the patient to work at this time? ☐ Yes ☐ No

If yes, please describe: _____

Based on objective findings and your medical opinion:

- The patient was totally disabled from: _____ through _____
- The patient was partially disabled from: _____ through _____

List all current restrictions and limitations you have placed on the patient's work and personal activities due to his or her medical condition (if none, indicate "none"):

Has the patient been released from your care? ☐ Yes ☐ No

- If yes date released from your care: _____
- If no, date of next scheduled treatment or evaluation: _____

ATTENDING PHYSICIAN'S DECLARATION AND SIGNATURE

NEW YORK RESIDENTS: 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 such violation.

I declare that the answers on this statement are complete and true to the best of my knowledge and belief. I understand that periodic updates (including providing copies of medical records when requested) will be required in the event of a continuing claim.

Provider's Signature | Date (MM DD YYYY)

Provider's Name (Please Print) | Specialty

Mailing Address (Street, Apt #, City, State, Zip)

Phone ( ) | Fax ( ) | Email Address