DISABILITY - CONTINUATION CLAIM FORM

************This form should only be used to continue an already approved disability*****************

PHYSICIAN STATEMENT

The Below Information Should Be Completed By Your Attending Physician Only

Patient Name: ___________________________________ **Member ID:** ________________________

Patient Date of Birth (DOB): _____ / ______ / _______

Nature of Illness / Injury: ____

Date of 1st Treatment: __________________ **Date of Last Treatment:** ____________________

Date of Next Appointment: ____________________

Date Patient May Return to Work (*if unknown, estimate*): __________________________________

Nature of Surgical Procedure Performed: ____

Patient Has Been Continuously Disabled From _______________ **Through** _____________________

Remarks/Restrictions: ____

Was Patient Referred to another Physician /Specialist (if Yes): Name: _________________________

Phone Number: ______________________

Completing Physician: I certify that the statements hereon are complete and accurate to the best of my knowledge.

Date: _______________ **Physicians Signature:** ____

Physicians Name (please print): ________________________________

Physicians Licensure/Degree: __________________________________

Physicians Address: ____

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Physicians Tax ID: ___________________ **Physicians Phone Number:** ____________________

Physicians Fax Number: _____________________

Please return this form via fax to 630-916-6847 / Attn: Disability Benefits