ATTENDING PHYSICIAN'S STATEMENT

Please Complete and Mail To:

VFIS
P.O. Box 5126, York, Pennsylvania 17405-9726
Call (717) 741-0911 · Toll Free: (800) 233-1957
Fax # (717) 747-7051

PLEASE COMPLETE THIS FORM IN FULL FOR PROMPT SERVICE.

NOTE: SEE ENCLOSED SHEET FOR IMPORTANT STATE INFORMATION.

Name of Patient _____ DOB _____

Address _____ Telephone _____

Regular Occupation _____

Name of Insured Organization _____ Policy No. _____

IMPORTANT

Have Insured Member (Patient) sign following Authorization

I hereby authorize any hospital, physician, or other person who has attended me or examined me to furnish to VFIS, Inc., any and all information with respect to any accident or illness, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Signature _____

Insured Member Patient

PART B – TO BE COMPLETED BY ATTENDING PHYSICIAN

The above named individual has filed a claim for benefits as a result of the Injury/Illness for which he/she is currently or has been under your care. In order that we might give his claim proper attention, would you kindly answer the following questions at your earliest convenience and forward completed form to us.

(1) Diagnosis and concurrent conditions (If fracture or dislocation, describe nature and location, If Sickness / Illness describe nature).

(2A) When did symptoms first appear or accident happen? Date _____

(B) When did patient consult you for this condition? Date _____

(C) Has patient ever had same or similar condition? (If Yes, state when and describe) ☐ Yes ☐ No

(3A) Nature of surgical procedure, If Any (Describe Fully) - Date Performed _____ ☐ Inpatient ☐ Outpatient

(B) If performed in hospital, give name and address:

(4) What other services, if any, did you provide patient?

(5) Is patient still under your care for this condition? ☐ Yes ☐ No
If "No" give date your services terminated. _____ Date _____

(6A) How long was or will patient be continuously totally disabled due to diagnosis in #1 above?
(Unable to perform Regular Occupation) From Date _____ Through _____

(B) How long was or will patient be partially disabled? From Date _____ Through _____

(C) Approximate date patient will return to work if still disabled Date _____

(7) Restrictions:

Date _____ Signature _____
(attending physician) (degree) (telephone no.)

Address _____

Fraud Warning

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Applicable in Arizona

For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

Applicable in California

For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Applicable in Colorado

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages.

Applicable in Florida

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Applicable in New Jersey

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Applicable in New York

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.

Applicable in Pennsylvania

WARNING: Any person who knowingly and with intent to injure or defraud any insurer files an application or claim containing any false, incomplete or misleading information shall, upon conviction, be subject to imprisonment for up to seven years and the payment of a fine of up to $15,000.

Applicable in Rhode Island

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Applicable in West Virginia

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Applicable in All Other States

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.