| Physician Statement Form | |
| --- | --- |
| **To be completed by Primary Insured** | |
| Primary Insured’s Name: | |
| Policy Number: | |
| Insurance Purchase Date: | |
| **To be completed by Examining Physician** | |
| Patient Information | |
| Patient’s Name: | |
| Date of Birth: | |
| Street Address: | City:....................State:....Zip Code:................ |
| Physician Information | |
| Exam Physician’s Name: | Speciality: |
| Street Address: | City:..................... State:.....Zip Code:............ |
| Phone: | Fax: |
| Tax identification number: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX-432F | |
| Are you the patient’s primary care physician? | |
| Yes | No  Who is this patient’s primary care physician?  Name:  Phone:  Was the patient referred to you by the primary care physician?  Yes/No: |

| Patient’s Diagnosis |  |
| --- | --- |
| Did you perform an actual examination? | Yes/No: |
| Date of the exam: |  |
| Please indicate the primary diagnosis for which you examined the patient: | |
|  | |
| ICD-9 Code: | |
| Date symptoms first appeared or accident occured: | |
| Is this condition a complication of an underlying condition? | Yes (specify below)/No |
|  | |
| Please list the dates of the patient’s office visits in the 120 days before the insurance purchase date, noted above. **Circle the dates where you treated the patient for the above stated condition.** | |
| \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_/ \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_/ | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_/ \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_/ |
| Did you advise the trip be canceled or interrupted due to the patient’s medical condition?: | |
| Yes: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_/ | No: |
| Please explain why you made this recommendation and provide details that you consider relevant to the insured’s decision to cancel or interrupt their trip due to injury or illness: | Please explain why you did not make this recommendation and provide details that you consider relevant to the insured’s decision to cancel or interrupt their trip due to injury or ilness: |
|  |  |
| If the patient is the insured, on what date did he/she become medically unable to travel? | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_/ |
| By my signature and stamp below, I hereby certify the above is true and correct: | |
| Payment: | |
| Amount: XXXXXX Paid: XXXXXX | Balance Due: XXXXX |
| Physician Signature: | Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_/ |
| Physician Stamp: | |
| Email to: xxxxxxxxxx.com  Mail to: XXXXXXX, XX, XXXX, 99999, XXXXXX, XX  Call: 0000000000  FAX: 000-000-0000  We are available 24 hours a day. | |

In this visual, we appreciate that Wellness Clinic physicians prepare statements for insurance companies regarding the services provided to either the insured or a customer on the insured’s plan. Besides patient’s information and Physician’s, we also find that data relevant for the insured’s payment plan with their provider. For example, Wellness Clinic includes the physician’s SSN for tax purposes and whether or not they are the patient’s primary care physician. Moreover, we learn that Wellness Clinic is required to breakdown the purpose of the visit, type of examination conducted, type of condition, and further actions taken, such as treatments and recommendations. Finally, the clinic adds the total amount of the services provide to the insured or insured’s dependents, amount paid, and outstanding balance.