Standard Insurance Company
866.851.5505 Tel 402.328.4029 Fax
PO Box 85508 Lincoln NE 6850l-5508

# Accident Benefits
# Attending Physician's Statement

## Instructions

- Insured or Patient to complete section A and submit to Attending Physician for completion.
- Attending Physician to complete sections B, C (if applicable) and D.
- Attending Physician to submit the completed and signed Attending Physician's Statement and supporting documentation to the address or fax number listed above.

## A. About the Insured and the Patient

### Insured's Information

| Full Name | Employer/Company Name | Group Policy No. |
|---|---|---|
| Alice Anderson | Acme Corp | ABCD |
| **Social Security No.** | **Date of Birth** | **Phone No.** |
| 123-45-6789 | 1/1/1980 | 315-315-3155 |

| Mailing Address | City | State | ZIP |
|---|---|---|---|
| 123 4th Ave | Smalltown | CA | 90009 |

### Patient's Information

| Full Name | Social Security Number | Date of Birth | Sex |
|---|---|---|---|
| | | | ☐ Male ☐ Female |

Patient's relationship to Insured: ☑ Self ☐ Spouse ☐ Domestic Partner ☐ Civil Union Partner ☐ Child

## B. About the Accident and Treatment - to be completed by Attending Physician. Please attach supporting documentation.

The Patient is responsible for obtaining a complete form without expense to The Standard.

| Date of Service | Diagnosis Description/ICD9 | Procedure Code (CPT) | Procedure Description |
|---|---|---|---|
| 1/6/2026 | Check-up on minor bruise | MB | |
| | | | |
| | | | |
| | | | |

Date of the Patient's accident or injury 1/1/2026

Was the Patient treated in the Emergency Room? ☐ Yes ☑ No If Yes, give date treated _____

Was the Patient treated in an urgent care facility? ☐ Yes ☑ No If Yes, give date treated _____

Has the Patient been hospitalized? ☐ Yes ☑ No

If Yes, give Admission Date _____ Discharge Date _____

Has the Patient undergone surgery? ☐ Yes ☑ No

If Yes, give date, procedure and result _____

If No, do you expect surgery to be performed in the future? ☐ Yes ☑ No

If Yes, give date and type of surgery _____

Name of Facility/Hospital where accident or injury was treated (including City, State and County)
Tom Medic Clinic, Smalltown CA 90009

Describe any other disease or infirmity affecting the patient's present condition and injury(ies). _____
N/A