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

Examining Physician's Name: _____ Specialty: _____

Street Address: _____ City: _____ State: ____ Zip Code: _____

Phone: (_____) _____ -- _____ Fax: (_____) _____ -- _____

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

E-mail to: claimsinquiry@allianzassistance.com
Mail to: Allianz Global Assistance, P.O. Box 72031, RICHMOND, VA 23255-2031
Call: 1-800-334-7525 Fax to: 804-673-1469. We are available 24 hours a day.

Insurance underwritten by BCS Insurance Company or Jefferson Insurance Company
Please refer to your policy or letter of confirmation to determine your underwriter
Plan administered by AGA Service Company

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 occurred: ____ / _____ / _____

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, . **Circle the dates where you treated the patient for the above stated condition.**

____ / _____ / _____	____ / _____ / _____	____ / _____ / _____	____ / _____ / _____
____ / _____ / _____	____ / _____ / _____	____ / _____ / _____	____ / _____ / _____

Did you advise the trip be cancelled or interrupted due to the patient's medical condition?

☐ Yes Date: ___ / ___ / _____

Please explain why you made this recommendation. Provide details on the circumstances and medical diagnosis of the patient that you consider relevant to the insured's decision to cancel or interrupt their trip due to injury or illness.

_____

_____

_____

_____

_____

☐ No

Please explain why you did not make this recommendation. Provide details on the circumstances and medical diagnosis of the patient that you consider relevant to the insured's decision to cancel or interrupt their trip due to injury or illness.

_____

_____

_____

_____

_____

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 that the above is true and correct

Physician Signature: _____ Date ____/____/_____

Physician Stamp:

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