

For Claims Customer Service:
For Claims Submission:

Phone: (877) 201-9373 x45708

Fax: (508) 853-2757

Email: DICIClaimsVB@trustmarkbenefits.com

Attending Physician Statement *(To be completed by Attending Physician of patient)*

Name of Patient: _____ Date of Birth: _____

1. History

- a. When did symptoms first appear or accident happen? _____
- b. Date patient ceased work because of disability? _____
- c. Has patient ever had same or similar condition? Yes No If Yes, state when and describe details:

- d. Names & addresses of other treating physicians: _____

2. Diagnosis *(Including any complications)*

- a. Diagnosis: _____
- b. Subjective Symptoms: _____

- c. Objective findings (including current X-rays, EKG's, Laboratory Data and any clinical findings)

3. Dates of Treatment

- a. Date of 1st visit? _____ b. Date of last visit? _____
- c. Frequency of visits? Weekly Monthly Other: _____

4. Provide Nature of Treatment *(Including surgeries, if any)*

Will treatment substantially improve functionality and employability? Yes No

5. Current Medications *(Including dosage and frequency)*

_____	Dosage _____	Frequency _____
_____	Dosage _____	Frequency _____
_____	Dosage _____	Frequency _____
_____	Dosage _____	Frequency _____
_____	Dosage _____	Frequency _____

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Attending Physician Statement – (Continued) *(To be completed by Attending Physician of patient)*

Name of Patient: _____ Date of Birth: _____

6. Physical Impairment *(Check One)*

- Class 1** – No limitations of functional capacity; capable of heavy physical activity. No restrictions. (0-10%)
- Class 2** – Slight limitation of functional capacity; capable of light manual activity. (15-30%)
- Class 3** – Moderate limitation of functional capacity; capable of clerical/administrative activity (Sedentary). (35-55%)
- Class 4** – Marked limitation. (60-70%)
- Class 5** – Severe limitations of functional capacity

Remarks: _____

7. Mental / Nervous Impairment *(If applicable)*

- Class 1** – Patient is able to function under stress and engage in interpersonal relations. **No limitations**
- Class 2** – Patient is able to function in most stress situations and engage in most interpersonal relations. **Slight limitations**
- Class 3** – Patient is able to function in only limited stress situations and engage in only limited interpersonal relations. **Moderate limitations**
- Class 4** – Patient is unable to engage in stress situations or engage in interpersonal relations. **Marked limitations**
- Class 5** – Patient has significant loss of psychological, physiological, personal and social adjustment. **Severe limitations**

Remarks: _____

Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof?

Yes No

8. Prognosis	Patient's Job		Any Other Work	
Is patient now totally disabled?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you expect a fundamental or marked change in the future?	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No	
If YES , when will patient recover sufficiently to perform duties?	_____	<input type="checkbox"/> 1 Mo <input type="checkbox"/> 1-3 Mos <input type="checkbox"/> 3-6 Mos <input type="checkbox"/> Never	_____	<input type="checkbox"/> 1 Mo <input type="checkbox"/> 1-3 Mos <input type="checkbox"/> 3-6 Mos <input type="checkbox"/> Never
If NO , please explain:				
Date released to work:	_____		_____	

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9. Remarks

Are you, the physician, related to this patient? Yes No If yes, what is the relationship?

May we communicate with you via email? Yes No If yes, Email Address: _____

Physician's Name: (please print): _____

Specialty: _____

Address: _____

Phone: (____) _____ Fax: (____) _____

Physician's Signature: _____ **Date Signed:** _____

*** Please attach copies of all medical records relating to the claimed condition including treatment notes and test results.**

**** If you require your own Disclosure Authorization to release information, please provide it directly to the patient.**