



ADA MEDCASH PLAN
P.O. BOX 1700
DENVER, COLORADO 80201
1-800-537-2033

ATTENDING PHYSICIAN'S STATEMENT - PLAN #1107

To Physicians:

The patient is responsible for the securing of this form and any charge, which may be made for its completion. Please complete the sections relating to your patient and strike out nonapplicable areas. This form should be mailed directly to Great-West.

Name of Patient: _____ ADA Association # _____

Patient's Address (No., Street, City, State, Zip): _____

Date of Birth: ___/___/___ Home Phone Number: (____) _____ Office Phone Number: (____) _____

I hereby authorize release of information requested on this form by the below named physician for the purpose of claim processing.

Handwritten Patient Signature _____ Date ___/___/___

1. History

- (a) Date symptoms first appeared or accident happened: ___/___/___ Date of first visit: ___/___/___
(b) Date patient first consulted you for this condition: ___/___/___ Date of last visit: ___/___/___
(c) Has Patient ever had same or similar condition? [] Yes [] No If "yes" state when and describe:

2. Critical Condition Category: (Please check appropriate category)

- [] Life Threatening Cancer [] Heart Attack [] Stroke [] Acquired Immune Deficiency Syndrome (AIDS) [] Multiple Sclerosis (MS)
[] Major Human Organ Transplant [] Motor Neuron Disease [] Amputation or Loss of Limb [] Kidney Failure [] Paralysis
[] Severe Burns [] Loss of Hearing [] Loss of Speech [] Coma [] Parkinson's Disease [] Major Head Trauma

3. Date of First Diagnosis: ___/___/___

4. List hospitalizations (if applicable):

Table with 2 columns: Names and addresses of Hospitals, Dates of Confinement. Includes rows for hospital names and dates.

5. List names and addresses of other treating Physicians and/or referrals (Please attach additional pages if necessary)

Table with 3 columns: Name and addresses of Doctors, Specialty, Date of last visit. Includes rows for doctor names and specialties.

6. IMPORTANT: Please supply the following:

Clinical findings (attach copies of laboratory, x-rays, diagnostic test reports and clinical notes covering the 12 month period preceding first diagnosis through the present.)

Name of Attending Physician (Please Print) _____ Degree/Board Certification _____ Telephone Number _____

Street Address _____ City/State _____ Zip Code _____

Signature _____ Date ___/___/___

Stamp or signature other than physician's own signature will not be accepted

NOTICE - Filing a statement of claim containing any false, incomplete, or misleading information with intent to defraud or deceive any insurance company is considered to be a felony in some states.