GREAT-WEST℠
FINANCIAL

MedCASH Plan
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1-866-257-0707 – Tel
1-303-737-2879 – Fax

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.

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):

Names and addresses of Hospitals	Dates of Confinement
	____/____/____ to ____/____/____
	____/____/____ to ____/____/____

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

Name and addresses of Doctors	Specialty	Date of last visit
		____/____/____
		____/____/____

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.