GREAT-WEST FINANCIAL

P.O. Box 17410
Denver, CO 80217-0410
1-866-257-0707 – Tel
1-303-737-2879 – Fax

SUPPLEMENTAL ATTENDING PHYSICIAN'S STATEMENT FOR VISION

NOTE: Great-West assumes no responsibility for any expense incurred in the completion of this statement. When completed, please mail or fax this statement directly to Great-West or return form to patient.

Please Print

Name of patient ____________________ Date of birth ____/____/____ (Month / Day / Year)

Patient's address ____________________
Number Street City State Zip Code

1105/1106/104GP
Plan number

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

Signed (Patient) ____________________

Date ____________________

1. History

(a) When did symptoms first appear or accident happen?................................ Mo. ______ Day ______ Year ______

(b) Date patient ceased work because of disability.. Mo. ______ Day ______ Year ______

(c) Names and addresses of other treating physicians

2. Current Findings

(a) Date of last examination.. Mo. ______ Day ______ Year ______

(b) Current diagnosis(es) (including any complications) ____________________

(c) Describe any pathology resulting in decreased visual acuity or constriction of fields (i.e. funduscopic or retinoscopy findings):

3. Dates of Treatment

(a) Date of first visit.. Mo. ______ Day ______ Year ______

(b) Date of last visit.. Mo. ______ Day ______ Year ______

(c) Frequency.. ☐ Weekly ☐ Monthly ☐ Other (specify)

4. Nature of Treatment (including date and type of surgery and medications prescribed, if any)

5. Progress

(a) Has patient.. ☐ Recovered? ☐ Improved? ☐ Remained unchanged? ☐ Retrogressed?

(b) Is patient.. ☐ Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confined?

(c) Has patient been hospital confined?... ☐ Yes ☐ No If "Yes" give name and address of hospital

____

____

Date of Admission _____/_____/_____ Date of Discharge _____/_____/______

6. Visual Impairment

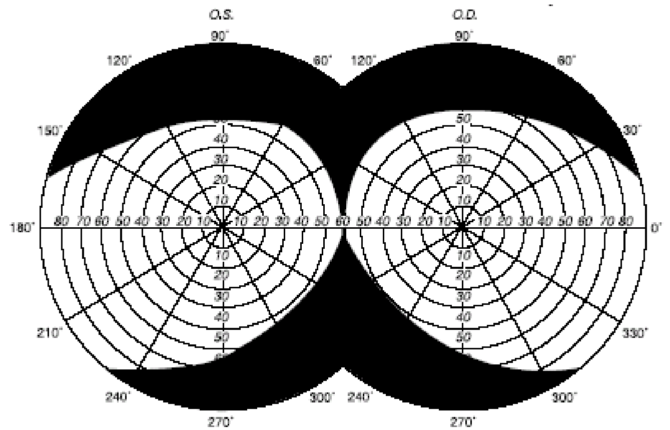
(a) What was vision at last observation?

With Glasses........................ O.D. ______ O.S. ______ Mo. _____ Day _____ 20 ___

Without Glasses................... O.D. ______ O.S. ______ Mo. _____ Day _____ 20 ___

(b) If fields of vision are contracted, show construction on chart

(c) Date corrected vision was irrecoverably reduced to 20/200 or less in the better eye:



(d) Vision can be restored in whole or in part by :

O.D. Lenses ☐ Treatment ☐ Operation ☐ Not restorable ☐
O.S. Lenses ☐ Treatment ☐ Operation ☐ Not restorable ☐

Mo. ____________ Day ________ Year_______ O.D. ☐ O.S. ☐

(e) How are the following affected by this patient's condition?

Reading –

Driving –

Tasks requiring visual discrimination –

Depth perception –

Peripheral vision –

7. Current Condition

(a) Is patient now totally disabled from his/her own occupation? ☐ Yes ☐ No

(b) Is patient now totally disabled from all occupations? ☐ Yes ☐ No

(c) If not now totally disabled, when was patient able to resume his/her regular duties? ☐ Part-time _______/_______/_______ ☐ Full-time _______/_______/_______

If part-time # of hours worked per week ___________

(d) What duties of patient's job is he/she incapable of performing?

Prognosis

Do you expect a fundamental or marked change in the future? ☐ Yes ☐ No

(a) If yes, when will patient recover sufficiently to perform his/her regular duties? ☐ 1 mo. ☐ 1-3 mo. ☐ 3-6 mo. ☐ Never

(b) If no, please explain:

8. Remarks and current treatment plan:

Name (Attending Physician) / **Please Print** ________ Degree / Specialty ________ ( ) Telephone ________

Street Address ________ ( ) Fax ________

City or Town ________ State ________ Zip Code ________

Signature* ________ Date ________

** Stamped signature or signature other than physician's own signature will not be accepted.*