ATTENDING PHYSICIAN STATEMENT - INITIAL CLAIM

Patient Information:
Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Policy/Claim Number: [Number]

Physician Information:
Name: [Physician Full Name]
Specialty: [Medical Specialty]
Address: [Clinic Address]
Phone: [Phone Number]

Medical Details:

Date of First Consultation for this condition: [Date]

Primary Diagnosis (including ICD code):
[Insert Diagnosis]

Secondary Diagnosis:
[Insert Diagnosis]

Objective Findings (Results of X-rays, lab tests, or clinical exams):
[Insert Findings]

Treatment Plan:

Current Medications: [List Medications]
Surgical Procedures (if applicable): [List Procedures]
Frequency of Treatment: [Weekly/Monthly/As Needed]

Functional Limitations:

In your medical opinion, what are the patient's specific physical or mental limitations regarding their work duties?
[Describe Limitations]

Estimated Duration of Disability:
From: [Start Date] To: [Expected End Date]

Physician Certification:

I hereby certify that the information provided is true and accurate to the best of my medical knowledge.

Signature: _____ Date: [Date]