

[Date]

[Physician Name]

[Clinic/Hospital Name]

[Address]

[City, State, Zip Code]

RE: Attending Physician Statement for [Patient Name]

Date of Birth: [Patient Date of Birth]

Policy/Claim Number: [Number]

Dear Dr. [Physician Last Name],

We are currently processing a [life/disability/health] insurance application/claim for your patient, [Patient Name]. To complete our evaluation, we require an Attending Physician Statement (APS) regarding the patient's medical history and current health status.

Please find the enclosed authorization form signed by the patient, which permits the release of their medical information to [Company Name].

Specifically, we request that you provide the following:

- A summary of the patient's medical history and diagnoses.
- Records of recent consultations, examinations, and laboratory results.
- Current treatment plans and medications.
- Prognosis and any physical or cognitive limitations, if applicable.

You may submit the completed statement and supporting documentation via:

- Fax: [Fax Number]
- Email: [Email Address]
- Mail: [Mailing Address]

Please advise if there is a fee associated with the preparation of this statement so that payment can be arranged promptly.

Thank you for your time and cooperation in this matter.

Sincerely,

[Your Name]

[Your Title]

[Company Name]

[Phone Number]