

Physician Statement Form

To be completed by Primary Insured

Primary Insured's Name: _____

Policy Number: _____

Insurance Purchase Date: _____

To be completed by Examining Physician

Patient Information

Patient's Name: _____

Date of Birth: ____ / ____ / ____

Street Address: _____ City: _____ State: ____ Zip Code: _____

Physician Information

Examining Physician's Name: _____ Specialty: _____

Street Address: _____ City: _____ State: ____ Zip Code: _____

Phone: (____) ____ -- _____ Fax: (____) ____ -- _____

Are you the patient's primary care physician?

 Yes No

Who is this patient's primary care physician?

Name: _____

Phone: (____) ____ -- _____

Was the patient referred to you by the primary care physician?

 Yes NoE-mail to: claimsinqury@allianzassistance.com

Mail to: Allianz Global Assistance, P.O. Box 72031, RICHMOND, VA 23255-2031

Call: 1-800-334-7525 Fax to: 804-673-1469. We are available 24 hours a day.

Insurance underwritten by BCS Insurance Company or Jefferson Insurance Company

Please refer to your policy or letter of confirmation to determine your underwriter

Plan administered by AGA Service Company

Patient's Diagnosis:

Did you perform an actual examination?

Yes

No

Date of the exam: ___ / ___ / _____

Please indicate the primary diagnosis for which you examined the patient:

ICD-9 Code: _____

Date symptoms first appeared or accident occurred: ___ / ___ / _____

Is this condition a complication of an underlying condition?

Yes (specify below)

No

Please list the dates of the patient's office visits in the 120 days before the insurance purchase date, . **Circle the dates where you treated the patient for the above stated condition.**

___ / ___ / _____	___ / ___ / _____	___ / ___ / _____	___ / ___ / _____
___ / ___ / _____	___ / ___ / _____	___ / ___ / _____	___ / ___ / _____

Did you advise the trip be cancelled or interrupted due to the patient's medical condition?

Yes Date: ___ / ___ / _____

No

Please explain why you made this recommendation. Provide details on the circumstances and medical diagnosis of the patient that you consider relevant to the insured's decision to cancel or interrupt their trip due to injury or illness.

Please explain why you did not make this recommendation. Provide details on the circumstances and medical diagnosis of the patient that you consider relevant to the insured's decision to cancel or interrupt their trip due to injury or illness.

If the patient is the insured, on what date did he/she become medically unable to travel? ___ / ___ / _____

By my signature and stamp below, I hereby certify that the above is true and correct

Physician Signature: _____ Date ___ / ___ / _____

Physician Stamp:

E-mail to: claims inquiry@allianzassistance.com
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Call: 1-800-334-7525 Fax to: 804-673-1469. We are available 24 hours a day.

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Plan administered by AGA Service Company