

NATIONAL SECURITY INSURANCE COMPANY

661 East Davis Street – Elba, Alabama 36323

1-800-239-2358

ATTENDING PHYSICIAN'S STATEMENT

PATIENT'S NAME AND ADDRESS

AGE

INSURED'S NAME IF PATIENT IS A DEPENDENT

POLICY NUMBER

DIAGNOSIS	1. DIAGNOSIS AND CONCURRENT CONDITIONS	
	2. (A) When did symptoms first appear? (B) When did patient first consult you for this condition? (C) Has patient ever had same or similar condition? If "Yes" state when and describe	Date _____ 20 ____ Date _____ 20 ____ Yes <input type="checkbox"/> NO <input type="checkbox"/>
	3. (A.) Nature of surgical procedure, if any. Describe fully giving date procedure was performed. (B.) If performed in hospital, give name of hospital	_____
SERVICE	4. Criteria used to base diagnosis. (List test or procedure and date performed.)	
	5. What other services, if any, did you provide patient: (Itemize giving dates)	
DEGREE OF DISABILITY	6. Is patient still under your care for this condition: If "no" give date your services terminated.	YES <input type="checkbox"/> NO <input type="checkbox"/> Date _____, 20 ____
	7. (A) How long was or is patient expected to be continuously totally disabled? (Unable to work)	From _____, 20 ____ thru _____, 20 ____
	(B) How long was or will patient be partially disabled?	From _____, 20 ____ thru _____, 20 ____
	8. To your knowledge does patient have any other health insurance or health plan coverage? If yes, identify	YES <input type="checkbox"/> NO <input type="checkbox"/>

DATE

Signature (Attending Physician)

Soc. Sec. No. or I.D. No.

Degree

Telephone

Address

City or Town

State or Providence

Zip Code

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any person or institution rendering treatment or any person or organization in possession of insurance or other benefit information concerning me or my dependents to furnish to or obtain from National Security Insurance Company or its representative full information regarding such treatment, insurance or other benefit information. A Photostat of this authorization shall be considered as valid as the original. I expressly Waive any provision of law which might prevent the disclosure of such information to the Company.

Date _____, 20 ____ .

Signed

Signature of Patient, Policyholder or responsible Party