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 ☐ No

E-mail to: claimsinquiry@allianzassistance.com
Mail to: Allianz Global Assistance, P.O. Box 72031, RICHMOND, VA 23255-2031
Call: @(claim_inquiry_phone) Fax to: 804-673-1469. We are available 24 hours a day.

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, noted above. **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: ___ / ___ / _________

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.

____

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☐ No

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.

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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: