



Physician Statement Form

To be completed by Primary Insured
Primary Insured's Name: _____
Policy Number: _____
Insurance Purchase Date: ____ / ____ / _____

To be completed by Examining Physician	
<u>Patient Information</u>	
Patient's Name: _____	
Date of Birth: ____ / ____ / _____	
Street Address: _____	City: _____ State: ____ Zip Code: _____
<u>Physician Information</u>	
Examining Physician's Name: _____	Specialty: _____
Street Address: _____	City: _____ State: ____ Zip Code: _____
Phone: (____) _____ -- _____	Fax: (____) _____ -- _____
Are you the patient's primary care physician?	<input type="checkbox"/> No
<input type="checkbox"/> Yes	Who is this patient's primary care physician?
	Name: _____
	Phone: (____) _____ -- _____
	Was the patient referred to you by the primary care physician?
	<input type="checkbox"/> Yes <input type="checkbox"/> No

E-mail to: claims inquiry@accessamerica.com
Mail to: ACCESS AMERICA, P.O. BOX 72031, RICHMOND, VA 23255-2031
Call: 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 World Access Service Corp., a company of Mondial Assistance

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: ___ / ___ / _____

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:

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