LOYAL AMERICAN LIFE INSURANCE COMPANY®
PO BOX 1604, DUNCAN, OKLAHOMA, 73534-1604
Phone (800) 366-8354, FAX 1-580-255-0951

ATTENDING PHYSICIAN'S STATEMENT OF CLAIM

TO BE FULLY COMPLETED BY YOUR PRIMARY TREATING PHYSICIAN.

SECTION I: PATIENT & INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (First, middle initial, last nam
2. PATIENT'S DATE OF BIRTH
3. INSURED'S NAME (First, middle initial, last name)
4. PATIENT'S ADDRESS (Street, city, state, zip)
5. PATIENT'S SEX ☐ MALE ☐ FEMALE
6. INSURED'S ID # or MEDICARE # (include any letters)
7. INSURED'S SOCIAL SECURITY #
8. INSURED'S POLICY #
9. DATE FIRST CONSULTED FOR THIS CONDI
10. DATE LAST TREATED
10. WAS PATIENT TREATED BY ANOTHER PHYSICAN(S), PRIOR TO YOUR TREATMENT ☐ YES ☐ NO
If 'YES', PROVIDE NAME & ADDRESS OF ALL PHYSICIAN'S KNOWN
11. DATE SYMPTOMS FIRST APPEARED
12. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS ☐ YES ☐ NO
IF 'YES', PROVIDE DETAILS INCLUDING DATES OF TREATMENT AND DIAGNOSIS
13. IF YOU REFERRED PATIENT TO ANOTHER PHYSICIAN, PLEASE PROVIDE NAME , ADDRESS OF PHYSICIAN, DATE OF REFERRAL
Date of Referral:
14. IS CONDITION DUE TO AN ACCIDENT ? ☐ YES ☐ NO
15. IF YES, HOW DID ACCIDENT HAPPEN?
16. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (if not home or office
17. DID YOU ORDER HOSPITAL CONFINEMENT ☐ YES ☐ NO
18. FOR SERVICES RELATED TO HOSPITALIZATION, NAME & ADDRESS OF FACILITY
DATE ADMITTED
DATE DISCHARGED
19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY
1.
2.
3.
4.
5.
20. SIGNATURE OF PHYSICIAN OR SUPPLIER
DATE
21. YOUR SSN
23. YOUR TAX ID #
22. PHYSICIAN'S/SUPPLIER'S NAME, ADDRESS, PHONE #