LOYAL AMERICAN LIFE INSURANCE COMPANY®

PO BOX 1604, DUNCAN, OKLAHOMA, 73534-1604
Phone (800) 366-8354

ATTENDING PHYSICIAN'S STATEMENT OF CLAIM		
TO BE FULLY COMPLETED BY YOUR PRIMARY TREATING PHYSICIAN.		
PATIENT'S NAME (First, MI, Last)	PATIENT'S DATE OF BIRTH	INSURED'S NAME (First, mi, last)
INSURED'S SOCIAL SECURITY #	PATIENT'S SEX ☐ Male ☐ Female	INSURED'S ID or MEDICARE # (include any letters)
PATIENT'S ADDRESS (Street, city, state, zip)	INSURED'S POLICY #	
DATE FIRST CONSULTED FOR THIS CONDITION:	DATE LAST TREATED:	WAS PATIENT TREATED BY ANOTHER PHYSICAN(S), PRIOR TO YOUR TREATMENT ☐ YES ☐ NO
IF YES PROVIDE NAME AND ADDRESS OF PHYSICIAN'S KNOWN:		
DATE SYMPTOMS FIRST APPEARED	HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS ☐ YES ☐ NO	
IF 'YES', PROVIDE DETAILS INCLUDING DATES OF TREATMENT AND DIAGNOSIS		
IF YOU REFERRED PATIENT TO ANOTHER PHYSICIAN, PLEASE PROVIDE NAME , ADDRESS OF PHYSICIAN, DATE OF REFERRAL:		
IS CONDITION DUE TO AN ACCIDENT? ☐ YES ☐ NO	IF YES, HOW DID ACCIDENT HAPPEN?	
NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (if not home or office)		
DID YOU ORDER HOSPITAL CONFINEMENT ☐ YES ☐ NO DATE ADMITTED: ____________________ DATE DISCHARGED: ____________________	FOR SERVICES RELATED TO HOSPITALIZATION, NAME & ADDRESS OF FACILITY	
19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY		
1.		
2.		
3.		
20. SIGNATURE OF PHYSICIAN OR SUPPLIER	21. YOUR SSN	22. PHYSICIAN'S/SUPPLIER'S NAME, ADDRESS, PHONE #
DATE	23. YOUR TAX ID #	