ATTENDING PHYSICIAN'S STATEMENT – SUPPLEMENT FORM

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TO BE COMPLETED BY THE PHYSICIAN OR PHYSICIAN'S REPRESENTATIVE

PLEASE ANSWER ALL QUESTIONS AND BE AS SPECIFIC AS POSSIBLE.

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1. NAME OF PATIENT _____ **DATE OF BIRTH** _____

2. NATURE OF ILLNESS OR INJURY _____

3. DESCRIBE ILLNESS OR INJURY (INCLUDING ANY COMPLICATIONS/DIAGNOSIS/PROGNOSIS): _____

_____

_____

4. IS CONDITION DUE TO PREGNANCY? YES ☐ **NO** ☐ **IF YES, EXPECTED DELIVERY DATE?** _____

PLEASE INDICATE MANNER OF DELIVERY: NORMAL ☐ **CESAREAN** ☐ **MISCARRIAGE** ☐

DID PATIENT SUFFER ANY DISABLING COMPLICATIONS DUE TO THE PREGNANCY? YES ☐ **NO** ☐

DESCRIBE COMPLICATIONS: _____

_____

5. DID THIS ILLNESS OR INJURY ARISE OUT OF PATIENT'S EMPLOYMENT? YES _____ **NO** _____

IF YES, EXPLAIN _____

_____

_____

6. GIVE DATES OF TREATMENT: OFFICE VISITS: _____

INPATIENT HOSPITAL: _____

OUTPATIENT: _____

SURGERY: _____

7. THE PATIENT HAS BEEN CONTINUOUSLY DISABLED (UNABLE TO WORK): FROM _____ **TO** _____
DATE **DATE**

8. PATIENT WAS OR WILL BE ABLE TO RETURN TO WORK *WITHOUT RESTRICTIONS* (APPROX): _____
DATE

9. PLEASE LIST ANY WORK RESTRICTIONS AND THE DATES: FROM _____ **TO** _____
DATE **DATE**

_____

_____

10. NEXT APPOINTMENT IS SCHEDULED FOR (DATE): _____

11. NAME OF ATTENDING PHYSICIAN: _____

CLINIC (IF APPLICABLE): _____

ADDRESS: _____

_____

TELEPHONE NO: _____ **FAX NO:** _____

PHYSICIAN'S SIGNATURE _____ **DATE** _____

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PLEASE ATTACH ANY INFORMATION YOU FEEL IS PERTINENT TO THIS CLAIM. COMPLETION OF THIS FORM IN ITS ENTIRETY WILL MEAN TIMELY PROCESSING OF THIS CLAIM. IF YOU HAVE QUESTIONS, CONTACT THE FUND OFFICE AT 414-258-2336 OR 800-255-3340. RETURN THE COMPLETED FORM TO FAX # (414) 258-9419 DURING BUSINESS HOURS M-F 8:00AM-4:30PM OR MAIL TO:

MILWAUKEE DRIVERS HEALTH AND WELFARE TRUST FUND

10020 WEST GREENFIELD AVENUE

MILWAUKEE, WI 53214

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