CHUBB

Hospital Accident Cash Claim
Attending Physician's Statement

MAIL TO:
P.O. Box 4000
Collegeville, PA 19426-9000
Phone: (610) 293-9229
Fax: (610) 293-9299
www.acitpa.com

Group Name: Alliance for Affordable Services (AAS)

Policy Number: 99070832

INSURED INFORMATION (Please print – Attach separate sheet if additional space required)

Insured's Name_____ **Soc. Sec. No.** _____-_____-_____ **Date of Birth** ____/____/___ **Marital Status** _____

Insured's Address_____ **Phone No. (H)**_____

_____ **Phone No. (W)**_____

Name and address of employer _____

Policy Number (Required)_____ **Insured's Occupation** _____

CLAIM INFORMATION

Date of accident: ____/ ____/____ **Date of first treatment:** _____/_____/_____

Please describe in detail the nature of the Insured's injuries, including all applicable ICD-9-CM codes:

_____

_____

Was the accident related to the Insured's occupation? _____ **If so, how?** _____

Was the Insured hospitalized? _____ **If yes, please list the names and addresses of all hospitals and all admission/discharge dates:**

_____

_____

Did the Insured have any injury or illness prior to the accident that contributed to the accident or to the Insured's present condition? ____
If yes, please describe: _____

_____

Were any surgical procedures performed? _____ **If yes, please list all procedures, including applicable CPT4 codes and dates performed:**

_____

_____

What are the Insured's current subjective symptoms? _____

_____

What are the objective findings? (please include results of current x-rays, lab tests, etc.,)? _____

_____

Dates of Hosptial Confinement:

From: _____/_____/_____ **through:** ____/____/____

Was the Insured seen by any other physician? _____ **If yes, please list the names and addresses of all other physicians:** _____

_____

ATTENDING PHYSICIAN INFORMATION

Name of Attending Physician: _____ **Phone No.** _____

Address: _____

I understand that any person who knowingly and with intent to defraud or deceive any insurance company files a claim containing any materially false, incomplete or misleading information may be subject to prosecution for insurance fraud.

SIGNED (Attending Physician) _____ **DATE** ___/____/____