ATTENDING PHYSICIAN'S STATEMENT

Submitting your claim

Submit your claim the way you like. Mail, email or fax your claim to:

Wellfleet Insurance Company
P.O. Box 15369
Springfield, MA 01115
Fax: 413-733-4612
Email: customerservice@wellfleetinsurance.com

Questions?

If you have any questions regarding available benefits or how to file your claim, or if you would like to appeal a determination, please contact our **Customer Service Team** at:

- customerservice@wellfleetinsurance.com
- 1-877-657-5030, Monday – Thursday 8:30 a.m. - 7:00 p.m. EST, Friday 8:30am-5pm EST

Patient's Name: ______________________________ DOB: ______________

1) Diagnosis: ______________________________
2) When did symptoms first appear (M/DD/YYYY)? ______________________
3) When did patient first consult you for this condition (M/DD/YYYY)? ______________________
4) Has patient ever had same or similar condition? ☐ Yes ☐ No
   If "yes", state when and describe: ______________________________
5) Describe any other diseases or infirmity affecting present condition.
   ____
6) Nature of surgical procedure, if any (describe fully).
   ____
7) Date patient last examined by you: ____________
   Frequency of visits: ☐ weekly ☐ monthly ☐ other ____________
8) If patient is hospitalized, provide name and address of hospital.
   Hospital: ______________________ City: ______________________ State: ________
9) Date admitted (M/DD/YYYY): ______________ Date discharged (M/DD/YYYY): ______________
10) Name and contact info of referring physician, if any.
    Name: ______________________________
    Phone: (_____) ______________________________
    Address: ______________________________
    City: ______________________ State: ____________ Zip: ____________

Return to work assessment

Did you advise the patient to stop work? ☐ Yes ☐ No

If yes, when (MM/DD//YYYY)? ______________________

Have you advised patient to return to work? ☐ Yes ☐ No

If yes, what is the expected return to work date (MM/DD//YYYY)? _________________ ☐ Full-Time ☐ Part-Time

If the patient can return to work, are there restrictions? ☐ Yes ☐ No

If yes, describe: ____

If no, please indicate the restrictions and limitations that prevent the patient from returning to work:

____

Physician verification

Signed: ____ Date: ________________ Phone: _______________________

Street Address: ____

City: ____ State: ______________ Zip Code: ____________________________