MEDICAL CERTIFICATE

Patient's Name:

Claim/Policy number:

ATTENDING PHYSICIANS CERTIFICATE

To be completed in full by the attending physician for all clinic, office, out-patient and short duration emergency room visits.

Doctor: your certificate will establish the validity of the claim. Please complete fully. Applicable to the insured person whose condition was the cause of this claim

The fields marked with a symbol ❖ are only to be completed if the patient is the claimant, their spouse, or their dependent child.

1. Was this an emergency medical condition? ◯ Yes ◯ No

❖2. Diagnosis / medical condition:

3. On what date did the patient first present to you or any other physician for symptoms of this condition? (physical or clinical)

❖4. If seen in follow up, please provide and attach clinical notes for all follow up dates entered below:

Follow up dates MM/DD/YY: 1. 3.

2. 4.

5. If known, date diagnosis determined?

❖6. Does the patient take prescribed medication for this condition ◯ Yes ◯ No

❖If yes, please provide details (if necessary attach list):

Name of drug	Date First Prescribed	Date Altered

7. If condition is pregnancy complications, what was the expected date of delivery?

*Additional Comments or notes:

Signature of attending Phyisican: Date:

Address:

City: Province: Country:

Postal Code: Telephone: Fax:

ATTENDING PHYSICIAN'S STAMP OR ATTACH LETTERHEAD OR PRESCRIPTION PAD

The insured is responsible for any fees charged for the completion of this medical certificate. For any inquiries, please call our Claims Customer Service Department at 1-800-263-8944.

RESET