MID AMERICA

EMPLOYEE BENEFIT ADMINISTRATION

ATTENDING PHYSICIAN'S STATEMENT

This form must be completed in full by the Attending Physician. It must be mailed or faxed directly identifiable from the Attending Physician's office only. The form will not be accepted if received from the applicant. The disabled dependent will not be enrolled (or coverage will cease to continue) until completed statement is received and reviewed by Mid-America Associates, Inc.

ADMINISTRATOR

MID-AMERICA ASSOCIATES, INC.
560 Kirts Blvd. Suite 125
Troy, MI 48084
Phone: 800-482-0945
Fax: (248) 583-4647

PATIENT IDENTIFICATION			
Patient Name (Last, First, Middle)		Social Security Number	Member ID Number
Date of Birth (MM/DD/YY)	Marital Status (circle one) Married Single	Sex (circle one) Male Female	Phone Number ( ) -
Patient Address		City State	Zip

PATIENT HISTORY	
How long have you personally known patient?	Date of your first visit with patient for illness claimed to have brought about present condition?
Number of visits?	Date of last visit?
What organ, system, or parts of the body is affected?	
Describe fully the course of the disease-it's initial symptoms-history of its progress.	
Has patient suffered from any aliments other than those above mentioned? If so, describe each case, and state how long it lasted and if recovery was complete?	
Has patient been attended to or prescribed for by any other physician or surgeon within three years? If so, what was the reason? Give name and addresses of all such physicians and surgeons:	

Is patient wholly and continuously unable to perform any work, or follow any occupation for compensation of profit?

If so, how long has patient been totally disabled?
If not disabled, is patient wholly and continuously unable to work?
Is the disability, in your opinion, likely to be temporary; permanent and total; or permanent and partial?
Please give any other facts of information, which in your judgment will aid in the correct solutions of the claims presented.
Please provide Physician's Medical Specialty:

Signature of Physician		Printed Name of Physician	Date
Signature of Patient for the release of this information		Printed Name of Patient	Date
Address of Physician		City	
State	ZIP	Phone Number ( ) -