Equitable™

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ATTENDING PHYSICIAN'S STATEMENT FOR COMPASSIONATE ADVANCE

Part 1: PATIENT AUTHORIZATION

Policy Number: _____

Name: _____ Date of Birth: DD / MM / YYYY

Address (number, street, city, province and postal code): _____

Phone Number (include area code): _____ Email address: _____

I hereby authorize the release to Equitable® and the owner of the insurance policy all medical and other information requested by Equitable in respect of this claim.

Patient's Signature	**Date**	DD / MM / YYYY

Part 2: ATTENDING PHYSICIAN'S STATEMENT

1. History

a) Date symptoms first appeared or accident happened DD / MM / YYYY

b) Has patient ever had the same or similar condition? ☐ No ☐ Unknown ☐ Yes, please provide details

c) Names and contact information of other treating physicians or health care providers.

2. Diagnosis (including any complications)

a) Primary

b) Subjective symptoms

c) Objective Signs (Please attach copies of current test results and all relevant clinical findings that support your diagnosis)

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Part 2: ATTENDING PHYSICIAN'S STATEMENT CONTINUED

3. Treatment

a) Date of first visit: DD / MM / YYYY

b) Date of last visit: DD / MM / YYYY

c) Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other (specify) _____

d) Nature of treatment: (including surgery, therapies and any medications prescribed)

e) To your knowledge is your patient following the recommended treatment program? ☐ Yes ☐ No, please comment

4. Progress

Has patient: ☐ Recovered ☐ Improved ☐ Not Improved ☐ Retrogressed

5. Prognosis

Is your patient's condition expected to result in a life expectancy less than 24 months? ☐ Yes ☐ No

6. Remarks

Please provide comments and further details which you feel would be helpful.

Name of attending Physician: (please print) _____

Specialty: _____

Telephone: _____ Fax: _____ Email address: _____

Address: (number, street, city, province & postal code): _____

_____

Physician's signature _____ Date: DD / MM / YYYY