ATTENDING PHYSICIAN'S STATEMENT

For Extended Health Care Expenses

Please Print

Group # ____________ **Certificate #** __________________________

Insured ____ **Patient** ______________________________

Physician Information *Name* ______________________________ *Tel.* ________________________

Address ______________________________

City, Prov., P.C. ______________________________

1. Diagnosis of Present Condition
   a) Primary ____
   b) Secondary ____
2. Date Condition Commenced *(yy/mm/dd)* ______________________________
3. Type of Treatment *(to include medication)* ______________________________
   Surgery Performed ____
4. Reason why the item to be rented/purchased is considered medically necessary
   ____
   ____
5. Length of time the specified item is required ______________________________
6. Estimated Cost a) Purchase $____________ b) Rental $____________ per month
7. Prognosis ____
8. Any pertinent information which would help to assess this unit
   ____
9. What activity is this equipment/appliance primarily used for
   ____

Authorization: I understand the information I provide on this form will be used to determine my eligibility for group insurance benefits claimed under this policy/plan. I certify that the charges listed above and for which the bills are attached, were incurred by myself or one of my eligible Dependents. The charges were incurred upon the recommendation and approval of the attending physician (where required by this policy/plan) and were required medical treatment. I declare that the statements made on this form are complete and true. I hereby authorize the release to RWAM Insurance Administrators Inc., of any information in respect to this claim requested by RWAM. This authorization will remain valid for as long as I am claiming benefits or service, or revoked in writing by myself.

A photocopy or facsimile transmission of this authorization shall be considered as valid as the original.

(The Patient is responsible for securing this form and for charges made for its completion.)

Date ________________ Patient's Signature ______________________________ Phone ________________

Date ________________ Physician's Signature ______________________________ Phone ________________

RWAM INSURANCE ADMINISTRATORS INC.

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