NAHGA
CLAIM SERVICES

WHERE **STELLAR SERVICE** IS NO ACCIDENT

ATTENDING PHYSICIAN'S STATEMENT

IMPORTANT: THIS FORM IS BEING REQUESTED IN RESPONSE TO MEDICAL CLAIMS THAT HAVE BEEN SUBMITTED. THIS FORM MUST BE COMPLETED AND RETURNED TO THE COMPANY. EACH DOCTOR'S BILL SUBMITTED MUST BEAR THE DOCTOR'S T.I.N. OR SOCIAL SECURITY NUMBER.

PATIENT'S NAME:_____

PATIENT'S AGE:_____DATE OF BIRTH: _____

NATURE OF SICKNESS OR INJURY (PLEASE DESCRIBE ANY COMPLICATIONS:

_____

_____

_____

IF INJURY, WHEN, WHERE, AND HOW DO YOU UNDERSTAND THE INJURY OCCURRED? _____

_____

WHAT DATE DID SYMPTOMS FIRST APPEAR OR ACCIDENT OCCUR?_____

WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION? DATE:_____

_____

HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION? (IF "YES", PLEASE STATE WHEN AND DESCIRBE):_____

_____

DATES OF TREATMENT:

_____

DENTAL INJURY (IF APPLICABLE)

IDENTIFY TEETH INVOLVED IN ACCIDENT AND INDICATE ON CHART:

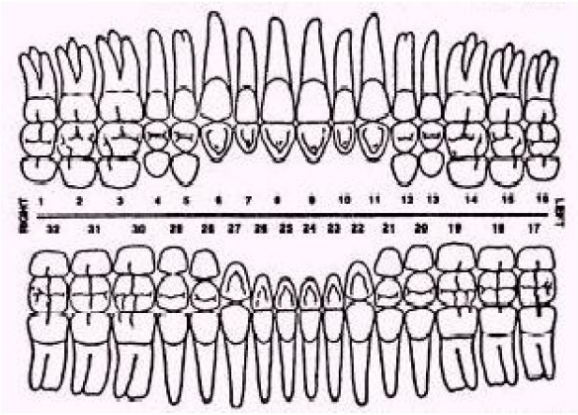
_____

DESCRIBE EXACT NATURE OF INJURY:_____

_____

CONDITION OF INJURED TEETH PRIOR TO ACCIDENT (CHECK THOSE THAT APPLY) **__**CLAIM CONSIDERATION WILL BE DELAYED IF LEFT BLANK****__:

NATURAL___WHOLE____SOUND_____FILLED_____CAPPED_____



SIGNED: _____

ADDRESS: _____**DATE:**_____

88 MAIN STREET | P.O. BOX 189 | BRIDGTON, ME 04009
O. (207) 647-3108 | **F.** (207) 647-4569
NAHGACLAIMSERVICES.COM