ATTENDING PHYSICIAN'S REPORT

DBMA 03_REV 7/17/14

CURRENT DATE	OUR POLICYHOLDER	CLAIM NUMBER	DATE OF ACCIDENT	POLICY NUMBER

DETERMINATION OF BENEFITS DUE UNDER "NO FAULT" AUTO INSURANCE LAW REQUIRES THE ATTENDING PHYSICIAN TO COMPLETE THIS REPORT AND RETURN IT DIRECTLY.

NOTICE: SECTION 817 234, FLORIDA STATUES, PROVIDES IN PART. ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE AN INSURANCE COMPANY FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

TO CLAIMS DEPARTMENT:

PATIENT'S NAME:		PATIENT'S ADDRESS: (STREET, CITY, STATE, ZIP CODE)
AGE:	SEX:	OCCUPATION: (IF KNOWN)
HISTORY OF OCCURRENCE AS DESCRIBED BY PATIENT: MVA		
DIAGNOSIS AND CURRENT OR CONTRIBUTING CONDITIONS:		
DATE WHEN SYMPTOMS FIRST APPEARED?		WHEN DID PATIENT FIRST CONSULT YOU FOR THIS CONDITION?
HAS PATIENT EVER HAD SOME SIMILAR CONDITION? IF YES, STATE WHEN AND DESCRIBE:		
IS CONDITION SOLELY A RESULT OF THIS ACCIDENT? YES NO IF NO, EXPLAIN		
IS CONDITION DUE TO AN INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT? YES NO		
WILL INJURY RESULT IN PERMANENT DISFIGUREMENT OR PERMANENT DISABILITY? YES NO IF YES, DESCRIBE		
PATIENT WAS DISABLED (UNABLE TO WORK) FROM: TO:		IF STILL DISABLED, DATE PATIENT SHOULD BE ABLE TO RETURN TO WORK?

REPORT OF SERVICES*

DATE OF SERVICE	PLACE OF SERVICE	DESCRIPTION OF SURGICAL OR MEDICAL SERVICES RENDERED	CHARGES
		SEE ATTACHED CLAIM FORMS	
		TOTAL CHARGE TO DATE	

IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? **YES** **NO**	ESTIMATED FUTURE CHARGES	**UNKNOWN**
PHYSICIANS NAME (PRINT):	PHYSICIANS IRS/TIN IDENTIFICATION NO:	
PHYSICIANS ADDRESS:	PHYSICIANS ADDRESS:	

***USE REVERSE SIDE IF ADDITIONAL SPACE IS NEEDED.**

PHYSICIANS SIGNATURE DATE COMPLETED