STATEMENT OF CLAIM - PERSONAL INJURY PROTECTION



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"A person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime."

·	ATT	ENDING PH	YSICIAN'S STATE	MENT				
	Name			Clain Number:				
PATIENT	Address							
·	Date of Birth	Gender ☐ Fema ☐ Male	le Occupation					
	History of occurr	ence as described by	Patient.					
PATIENT'S CONDITION	Diagnosis (ICD-9 Code), concurrent, comorbid, and contributing conditions. *							
	Date when symp	oms first appeared.	Date when Patient first consu	ulted you for this condition.				
	Has Patient ever condition?	had same or similar	If Yes, state when and descri	be. *				
	☐ Yes☐ No							
HOSPITAL	Was patient hosp ☐ Yes ☐ No	italized?	If "Yes," name of hospital.					
·	Period of Hospit		/ / Throug	h / ' /				
	Is condition sole accident?	ely a result of this	If "No," explain. *	,				
CAUSE OF	☐ Yes							
CONDITION	☐ No Is condition due	to injury or	If "Yes," describe. *	or and the second secon				
	sickness arising	out of the Patient's	a ros, describes.					
	employment? ☐ Yes							
	□ No		Contracting the second superior section (All Contracting Contracti					
DISABILITY	Will injury resuldisfigurement or ☐ Yes		If "Yes," What is the Disabi	lity Rating? *				
	□ No							
OTHER INSURANCE		e Individual /Group c / HMO / Other?	If "Yes," Organization's Nar	ne and Address				
	□ No	•						
	* Ple	ase use space be	low if additional space i	s needed				
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CLAIMS AUTHORIZATION TO RELEASE INFORMATION

I authorize any licensed physician, medical practitioner, pharmacist, hospital, HMO, other medical or medically-related facility, federal, state or local government agency, insurance or reinsuring company or Plan Sponsor/Administrator, employer or former employer having information available as to diagnosis, treatment or prognosis with respect to any physical or mental condition and/or treatment of me, and/or any non-medical information about me including any information regarding my occupation and salary, to give any and all such information to the particular Company in the Liberty Mutual Group to which I am submitting a claim, its employees, legal representatives or other persons or organizations providing claims management services.

I understand this Authorization could include information with respect to HIV infection, AIDS, mental health and alcohol and substance abuse.

I understand the information obtained by use of this Authorization will be used by the Company to investigate my claim. Any information obtained will not be released by the Company to any person or organization except reinsuring companies, or other companies in the Liberty Mutual group of companies to which I submit a claim for benefits, other persons or organizations performing a business or legal service in connection with my claim, or as may be otherwise permitted or required by law.

I know that I may request a copy of this Authorization. I agree that a photographic copy of this Authorization shall be as valid as the original.

I understand that this Authorization shall be valid for the duration of the claim or two years from the date appearing below my signature, whichever event occurs earlier, and that I have the right to revoke this authorization at any time by written notification to the Company in the Liberty Mutual Group to which I have submitted a claim.

If the patient is a minor, the signature found below shall be that of the patient's authorized representative.

Signature of Patient or Authorized Representative of Patient	Social Security Number
Print Name	Date
Claim Number	