State Mutual Insurance Company

Platinum® SUPPLEMENTAL INSURANCE

Physician's Statement

PATIENT'S & INSURED INFORMATION

1. PATIENT'S NAME (First Name, Middle Int. Last Name)		2. PATIENT'S DATE OF BIRTH
3. PATIENT'S ADDRESS (Street, City, State, ZIP)		4. TELEPHONE NO. ( )
5. PATIENT'S SEX MALE ❑ FEMALE ❑	6. PATIENT'S RELATIONSHIP TO INSURED SELF ❑ SPOUSE ❑ CHILD ❑ OTHER ❑	7. INSURED'S POLICY NUMBER
8. INSURED'S NAME (First Name, Middle Int. Last Name)		9. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES ❑ NO ❑ B. AN AUTO ACCIDENT YES ❑ NO ❑
10. INSURED'S ADDRESS (Street, City, State, ZIP)		

PHYSICIAN OR SUPPLIER INFORMATION

12. DATE OF ILLNESS (FIRST SYMPTOM OR INJURY (ACCIDENT OR PREGNANCY)	13. DATE FIRST CONSULTED YOU FOR THIS CONDITION	14. HAS PATIENT HAD SAME OR SIMILAR SYMPTOMS? YES ❑ NO ❑
15. IS THIS INJURY OR SICKNESS WORK RELATED? YES ❑ NO ❑	16. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE	

17. FOR HOSPITALIZATION, LIST DATES: ADMITTED DISCHARGED

18. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED (If other than home or office)

19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

1._____ 3. _____

2._____ 4. _____

20. A. DATE OF SERVICE From: mm/dd/yyyy To: mm/dd/yyyy	B. PLACE OF SERVICE	C. CPT/HCPCS	D. MODIFIERS	E. DIAGNOSIS POINTER	F. CHARGES		G. DAYS OR UNITS
					21.TOTAL CHARGES		

22. SIGNATURE OF PHYSICIAN OR SUPPLIER

SIGNED **DATE**

23. FEDERAL TAX I.D. NUMBER SSN# ❑ EIN# ❑	24. PATIENT'S ACCOUNT NO.	25. AMOUNT PAID

26. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP, & TELEPHONE #.

State Mutual Insurance Company - Platinum Claims
Mail: PO Box 1404 / Rome, GA 30162 Fax: 813-386-4425