

Medical Statement Form Sample

This **medical statement form sample** is designed to streamline the process of submitting accurate and comprehensive information for insurance claims. It ensures clarity and completeness, facilitating faster claim approvals. Using this template helps both patients and providers maintain organized health records.

1. Patient Information

Full Name:

Date of Birth:

Insurance Policy Number:

Contact Number:

2. Provider Information

Provider Name:

Facility/Clinic Name:

Provider Contact Number:

3. Medical Diagnosis & Statement

Diagnosis (ICD-10 if available):

Brief Description of Condition:

Dates of Treatment:

e.g., 2024-03-01 to 2024-03-10

Procedures or Services Provided:

Recommendations / Follow-up:

4. Attending Physician Certification

Attending Physician Name:

Signature:

Date:

By signing, I certify that the information provided above is accurate and complete to the best of my knowledge.

Submit Form