Medical Statement Form
For Disability Benefits Application

This **medical statement form** sample is designed to assist in documenting essential health information for disability benefits claims. It ensures accurate and comprehensive medical evidence is provided to support the eligibility evaluation process. Using this form helps streamline the application and increases the likelihood of approval.

Applicant Information

Full Name:

Date of Birth:

Social Security Number (Last 4 digits):

Address:

Phone Number:

Treating Physician Information

Physician's Name:

Medical Facility/Practice Name:

Contact Number:

Physician License Number:

Medical Information

Diagnosis:

Relevant Symptoms:

Date of Onset:

Treatment and Medications:

Functional Limitations/Disabilities:

Estimated Duration of Disability:

--Please select--

Physician's Statement

Summary of Medical Necessity and Recommendation for Disability Benefits:

Physician's Signature:

Date:

Applicant's Signature:

Date: