WELLFLEET
WORKPLACE

ATTENDING PHYSICIAN'S STATEMENT

Submitting your claim

Submit your claim the way you like. Mail, email or fax your claim to:

Wellfleet Insurance Company
P.O. Box 15769
Springfield, MA 01115
Fax: 413-452-5486
Email: workplaceclaims@wellfleetinsurance.com

Questions?

If you have any questions regarding available benefits or how to file your claim, or if you would like to appeal a determination, please contact our **Customer Care Team** at:

- workplaceclaims@wellfleetinsurance.com
- 1-855-664-5838, 8:30 a.m. - 5:00 p.m. EST

Patient's Name: _____ DOB: _____

1) Diagnosis: _____
2) When did symptoms first appear (M/DD/YYYY)? _____
3) When did patient first consult you for this condition (M/DD/YYYY)? _____
4) Has patient ever had same or similar condition? ☐ Yes ☐ No
   If "yes", state when and describe: _____
5) Describe any other diseases or infirmity affecting present condition. _____
   _____
6) Nature of surgical procedure, if any (describe fully). _____
   _____
7) Date patient last examined by you: _____
   Frequency of visits: ☐ weekly ☐ monthly ☐ other _____
8) If patient is hospitalized, provide name and address of hospital.
   Hospital: _____ City: _____ State: _____
9) Date admitted (M/DD/YYYY): _____ Date discharged (M/DD/YYYY): _____
10) Name and contact info of referring physician, if any.
    Name: _____ Phone: (_____)_____
    Address: _____
    City: _____ State: _____ Zip: _____

Return to work assessment

Did you advise the patient to stop work? ☐ Yes ☐ No

If yes, when (MM/DD//YYYY)? _____

Have you advised patient to return to work? ☐ Yes ☐ No

If yes, what is the expected return to work date (MM/DD//YYYY)? _____ ☐ Full-Time ☐ Part-Time

If the patient can return to work, are there restrictions? ☐ Yes ☐ No

If yes, describe: _____

If no, please indicate the restrictions and limitations that prevent the patient from returning to work: _____

_____

Physician verification

Signed: _____ Date: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____