Fenchurch General Insurance Company

Supplemental Medical Information Request

To Attending Physician,

The information provided through this submission will be used in the adjudication of your patient's claim for disability benefits. Please answer all questions as clearly and completely as possible. Incomplete or illegible entries may delay or negate future payment of benefits. Please attach additional sheets as required. Thank you in advance for your time and attention to this matter and your ongoing professional support to our claimant.

** ANY COST ASSOCIATED WITH THE COMPLETION OF THIS REPORT RESTS WITH THE CLAIMANT**

Patient Information		
Surname:	**First Name:**	**Date of Birth:**
Employer:		**Occupation:**
To Be Completed By Attending Physician (Please Print Clearly)		
Primary Diagnosis (for psychiatric diagnosis include DSM-IV GAF):		**Axis I –** **Axis II –** **Axis III –** **Axis IV –** **Axis V –**
Secondary Diagnosis:		
Objective Findings: **(Mental or Cognitive diagnosis require a Mental Status Exam with validity measures and for physical / musculoskeletal disorders require functional, ROM and/or diagnostic testing results to be supplied)**		
Subjective Findings:		
When did symptoms first appear?		
Date of first visit during current period of disability:	**First date of disability due to condition:**	
Date of last visit:	**Frequency of visits:** ☐ **Weekly** ☐ **Monthly** ☐ **Other**	

Has your patient undergone surgery ☐ **Yes** ☐ **No**

If yes, please give date, describe procedure and result:

Will your patient undergo surgery in future? ☐ **Yes** ☐ **No**

If yes, please give date and describe procedure to be performed:

What medication(s) is your patient currently taking or been prescribed?

Please indicate other types and frequencies of treatments:

To your knowledge, is the patient following the recommended treatment program? ❑ **Yes** ❑ **No**

Current Medical Status

Please include any changes made in your patient's treatment plan and any complications.	☐ Improved ☐ Unchanged ☐ Worse	Comments:

Diagnostic Procedures and Tests

Please specify any tests that have been completed or are scheduled – provide copies of all reports and/or test results.	

Referrals

Please provide copies of any specialist consultation and/or progress reports.	Referral to:	Specialty:
	Referral to:	Specialty:
	Referral to:	Specialty:

Functional Limitations and Return to Work Planning

Is your patient able to return to work in their own occupation? If yes, please provide an estimated return to work date and any limitations to return to work. If return to work is not an option, please clearly outline the functional limitations (cognitive and/or physical) that preclude the patient from the workplace.

Is your patient able to return to work in any occupation? If yes, please provide an estimated return to work date and any limitations to return to work. If return to work is not an option, please clearly outline the functional limitations (cognitive and/or physical) that preclude the patient from the workplace.

Mailing and Faxing Information

Fax or email the completed form (we do not require originals)	**Fenchurch General Insurance Company** 55 University Ave, Suite 1604 Toronto, ON M5J 2H7	**Fax Number** 1-877-364-6666	**Email** claims@fenchurchgeneral.com

Physicians Signature

Date

Physicians Name/Specialty/License Number

Telephone Number

Fax Number