

Physician Statement Form

Return to: World Access
PO Box 72031
Richmond, VA 23255-2031
Fax: 1-804-673-1469

This form is to be completed by the physician who advised you or your family member to cancel or interrupt your trip. To ensure a prompt response, please make sure every question is answered on this form.

Patient Information

Patient's Name: _____ Date of Birth: ____/____/____

Patient's Address: _____

City, State, Zip Code: _____

Physician Information

Physician who advised cancellation/interruption: _____

Physician's Address: _____

Physician's Phone #: (____) _____ Fax #: _____

Specialty: _____

Are you the patient's primary care physician? _____ YES _____ NO

If no, who is? _____

If no, was the patient referred to you by the primary care physician? _____ YES _____ NO

Patient's Diagnosis

Please indicate the primary diagnosis for which you advised cancellation/interruption of your patient's travel plans:

ICD-9 Code _____ Date symptoms first appeared or accident occurred _____

Please list the dates of the patient's last 5 office visits and **circle the dates where you treated the patient for the same condition.**

_____, _____, _____, _____, _____

Did you advise cancellation/interruption of the trip? _____ YES _____ NO

Did you perform an actual examination when you gave this advice? _____ YES _____ NO

Was the patient Medically Stable/Able to Travel on the date the insurance was purchased? _____ YES _____ NO

Insurance was purchased on : ____/____/____

Date you advised cancellation ____/____/____

By my signature and stamp below, I hereby certify that the above is true and correct and that I performed an examination of the patient at the time I recommended cancellation/interruption of his/her travel plans.

Physician Signature: _____ Date Signed: ____/____/____