



ATTENDING PHYSICIAN'S STATEMENT

Please Print

Group # _____ Certificate # _____

Insured _____ Patient _____

Physician Information Name _____ Tel. _____

Address _____

City, Prov., P.C. _____

1. Diagnosis of Present Condition
 - a) Primary _____
 - b) Secondary _____

2. Date Disability Commenced (yy/mm/dd) _____

3. Type of Treatment (to include medication) _____
Surgery Performed _____

4. Reason why the item to be rented/purchased is considered medically necessary

5. Length of time the specified item is required _____

6. Estimated Cost a) Purchase \$ _____ b) Rental \$ _____ per month

7. Prognosis _____

8. Any pertinent information which would help to access this unit

9. What activity is this equipment/appliance primarily used for

Authorization: I understand the information I provide on this form will be used to determine my eligibility for group insurance benefits claimed under this policy/plan. I certify that the charges listed above and for which the bills are attached, were incurred by myself or one of my eligible Dependents. The charges were incurred upon the recommendation and approval of the attending physician (where required by this policy/plan) and were required medical treatment. I declare that the statements made on this form are complete and true. I hereby authorize the release to RWAM Insurance Administrators Inc., of any information in respect to this claim requested by RWAM. This authorization will remain valid for as long as I am claiming benefits or service, or revoked in writing by myself.

A photocopy or facsimile transmission of this authorization shall be considered as valid as the original.

(The Patient is responsible for securing this form and for charges made for its completion.)

Date _____ Patient's Signature _____ Phone _____

Date _____ Physician's Signature _____ Phone _____

RWAM INSURANCE ADMINISTRATORS INC.

49 Industrial Drive, Elmira, Ontario N3B 3B1 Tel. 519-669-1632, 1-877-888-RWAM (7926) Fax 519-669-1923 www.rwam.com