



CONTINUING CLAIM FORM

Full Name _____ Claim Number _____

Address _____ Phone No. _____
Street City State Zip

IF YOU HAVE RETURNED TO WORK OR YOU HAVE BEEN RELEASED BY YOUR DOCTOR TO RETURN TO WORK, CONTACT NORTH AMERICAN INSURANCE COMPANY IMMEDIATELY TO ENSURE BENEFITS ARE APPROVED APPROPRIATELY.

ATTENDING PHYSICIAN STATEMENT

Diagnosis / medical status: _____

Is your patient currently totally disabled? Yes No

If "No" date released ____/____/____

If "Yes" ESTIMATED release date ____/____/____

Is your patient currently partially disabled? Yes No

If "No" date released ____/____/____

If "Yes" ESTIMATED release to full-duty ____/____/____

If disabled, please fully provide limitations, results of any objective tests (i.e., lab, x-rays, MRI's, CT scan, etc.):

Your treatment plan as it relates to your patient's returning to work: _____

Have you discussed returning to work or commencing a vocational rehabilitation program with your patient? Yes No

Frequency of treatment: Weekly Monthly Other (Specify): _____

Date last treated ____/____/____

When do you anticipate an increase in your patient's functional capabilities? _____

Signature _____ Date ____/____/____

DO NOT PRE-DATE

Physician's Name _____ Degree _____ Specialty/Board certification _____

Physician's Address _____
STREET CITY STATE/ZIP

Physician's Phone Number () _____ Physician's Fax Number () _____