OXFORD
LIFE INSURANCE COMPANY

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 OXFORD LIFE NSURANCE 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 ( )____________________

Mail Completed Form To: 2721 N. Central Ave. – Phoenix, AZ 85004
Phone 800-585-5821 – Fax 602- 263-6993

CCF1/OX Rev. 03/05