Trustmark
benefits beyond benefits

Critical HealthEvents
Additional Sickness – Standard Activities Claim

For Claims Customer Service: ☎ **Phone:** (877) 201-9373 x45708
For Claims Submission: 🖷 **Fax:** (508) 853-2757 ✉ **Email:** DICIClaimsVB@trustmarkbenefits.com

Attending Physician Statement *(To be completed by the Attending Physician)*

PLEASE PROVIDE ANY SUPPORTING MEDICAL RECORDS RELATED TO THE BELOW

Name of patient _____ Date of birth _____

Date patient **1st** reported symptoms: _____

Date of **1st** treatment: _____ Dates of subsequent treatments: _____, _____, _____, _____

Is this condition due to: an Accident ❑ a Sickness ❑ ?

Did another physician refer this patient to you? Yes ❑ No ❑ If yes, please list:

Name: _____

Address: _____

Patient's Condition Primary Diagnosis_____

Subjective symptoms_____

Based on your findings, please check **ALL** Standard Activities your patient is not able to perform as a result of the above diagnosis?

❑ **Bathing** – the ability to wash oneself in either a tub or shower, or by sponge bath; including the tasks of getting into and out of the tub or shower with or without the assistance of equipment.
❑ **Dressing** – the ability to put on, take off, and secure all necessary and appropriate items of clothing and any necessary braces or artificial limbs.
❑ **Toileting** – the ability to get to and from the toilet, get on or off the toilet, and perform associated personal hygiene with or without the assistance of equipment.
❑ **Transferring** – the ability to move in and out of bed, chair, or wheelchair with or without the assistance of equipment; mobility, the ability to walk or wheel on a level surface from one room to another with or without the assistance of equipment.
❑ **Eating** – the ability to get nourishment into the body by any means once it has been prepared and made available to one with or without the assistance of equipment.
❑ **Continence** – the ability to voluntarily maintain control of bowel and/or bladder function or in the event of incontinence, the ability to maintain a reasonable level of personal hygiene.

When did these Standard Activity Limitations begin? _____

How long are these Limitations expected to last? ❑ 1 mo. ❑ 2 mo. ❑ 3 mo. ❑ More than 3 mos.

Do you believe the patient requires Professional care? Yes ❑ No ❑

If No, do you believe the patient's Spouse is able to provide care for your patient with the above checked activities of daily living? Yes ❑ No ❑

Is patient competent to endorse checks and direct the use of proceeds thereof? Yes ❑ No ❑

Physician's name (please print) _____

Degree _____ Specialty_____

Phone(_____)-_____-_____ Fax(_____)-_____-_____

Address_____

Signature_____ Date _____

Are you, the physician, related to this patient? ❑ Yes ❑ No If yes, what is the relationship?