MICHIGAN MOTOR VEHICLE NO-FAULT INSURANCE LAW

ATTENDING PHYSICIAN'S REPORT

Date	Our Policyholder	Date of Accident	File Number

NOTICE: ANY PERSON WHO KNOWINGLY AND WITH THE INTENT TO INJURE OR DEFRAUD ANY INSURER FILES AN APPLICATION OR CLAIM CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION SHALL, UPON CONVICTION, BE SUBJECT TO IMPRISONMENT FOR UP TO 1 YEAR FOR AS MISDEMEANOR CONVICTION OR UP TO 10 YEARS FOR A FELONY CONVICTION AND PAYMENT OF A FINE OF UP TO $5,000.00.

To assist us in determining benefits due under the Michigan Motor Vehicle No-Fault law, the attending physician must complete this report. You are required to provide this information in accordance with the Michigan Motor Vehicle No-Fault Insurance law, P.A. 294 of the Public Acts of 1972.

Patient's Name and Address

Age	Occupation/Job Description

History of Occurrence and Injury as Described by Patient

Diagnosis and Concurrent Conditions*

When did symptoms first appear?	When did patient first consult you for this condition?
Date:	Date:

Have you treated patient before this date? If yes, when?

Has patient ever had same or similar condition? If yes, state when and describe*

☐ Yes ☐ No ☐ Undetermined

Is patient able to perform routine household chores? If no, please explain and indicate projected duration of inability.

☐ Yes ☐ No

Will patient require attendant care? If yes, please explain and indicate projected duration.

☐ Yes ☐ No ☐ Undetermined

Patient was unable to work	If still disabled, patient should be able to return to work on
From: Through:	Date:

*Use a separate sheet if necessary

(see reverse side)

If patient was hospitalized, name of hospital	Period of Hospitalization From: To:

Is patient still under your care for this condition? ☐ Yes ☐ No

If yes, indicate projected duration and frequency of treatment:

*** REPORT OF SERVICES **

Attach itemized bill(s) for this accident only, and include amounts paid or payable by other sources. Attach verification of payment or rejection.

IRS/TIN Identification Number

Physician's Name (Please Print)

Address

Physician's Signature

Date:

City, State, Zip Code

Telephone Number