

## Workers' Compensation Attending Physician Benefits Form

**Return completed form to the Third-Party Administrator  
American Mining Claims Service  
PO Box 660988  
Birmingham, AL 35266-0988  
Fax: 866-759-9843**

<b>Physician</b>	Claimant Name:	Social Security Number:
	Date of Injury:	Claim Number:
	Employer:	Physician Name:
	Estimated <input type="checkbox"/> Transitional <input type="checkbox"/> Full Duty Return-To-Work Date:	
	Maximum Medical Improvement: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Ready for Permanent Partial Disability Rating: <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Estimated Period of Disability From _____ To _____	
	Current Appointment Date:	Next Appointment Date:
	<p>Physicians completing this form are required to submit updated detailed medical reports to include current treatment plans related to this claim in a timely manner after each office visit. The completion of this form without the detailed medical information noted above does not guarantee that temporary total disability benefits will be paid.</p> <p>Physician's signature: _____ Date: _____</p>	

<b>Claimant</b>	<p>Have you performed any kind of work or have you received income for any work during the time you have been certified temporarily and totally disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
	<p>I hereby certify that the statement and answer set forth above are true and correct to the best of my knowledge and belief. I am aware that the law provides for severe penalties if I knowingly and with fraudulent intent withhold a material fact or make a false statement in order to obtain or increase a benefit to which I am not entitled.</p> <p>Claimant's signature: _____ Date: _____</p>

**Failure to complete this form in its entirety will affect the payment of temporary total disability benefits in this claim.**