MSG# 1727366707-006-1

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Please fax the completed form to: Fax Number: 866-411-5613 The Hartford P.O.Box 14301 Lexington, KY 40512-4301



ATTENDING PHYSICIAN'S STATEMENT - PROGRESS REPORT

		Date of Birth:	Insured IDNumber:			
Patient Address: (Street, City, State & Zip	Code)	SOMMANGE CO.				
To be completed by the Provider - Use			visit or examination to			
complete this form. (The patient is respons Medical Conditions Impacting Activity	lible for the completion of this form without ex	pense to the Company.)				
** 1		ICD-9 Code	E [""			
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Secondary condition(s):		ICD-9 Code	<u>, </u>			
		ICD-10 Cod	e(s):			
Subjective symptoms:		***************************************				
Objective Physical Findings (Please include	office notes for date(s):	to	ACCOUNTS TO THE PROPERTY OF TH			
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Pertinent Test Results (list all results or		PROPERTY OF THE PROPERTY OF TH				
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Test:Condition(s) Specific Medications, Dosage	Date:	Results:	VANDARIA (1888)			
Test:Condition(s) Specific Medications, Dosage	Date:	Results:				
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Test:Condition(s) Specific Medications, Dosage TREATMENT PLAN Current Treatment Plan:	Date:	Results:				
Test: Condition(s) Specific Medications, Dosage TREATMENT PLAN Current Treatment Plan: What is the Frequency / Duration of Treatment	Date: and Frequency: pent? Dates of T	reatment:				
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Add	litional Comments (If	Necessary)	* *	**************************************	***************************************		\$6.000.00 T	**************************************	WIREARP DE ACONT SASSAULT PROPERTY AND ACONT ACCOUNT OF THE ACOUNT ACCOUNT OF THE ACOUNT ACCOUNT OF THE ACCOUNT OF THE ACOUNT ACCOUNT OF THE ACCOUNT OF THE ACOUNT ACCOUNT OF THE		
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Office Contact and Telephone Number:											
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