SEIU LOCAL 1 & PARTICIPATING EMPLOYERS HEALTH TRUST
Claims Department
111 East Wacker Drive, Suite 1700
Chicago, IL 60601
(312) 233-8899

SUPPLEMENTAL MEDICAL REPORT

Patient: ____________________________________ **SS#** ________________________________

Address: ____________________________________ **Date of Loss:**__________________________

In order for the above to continue benefits, additional information is needed. Please have your physician complete and return this form to the Fund Office as soon as possible.

1. **Date of last visit**: ____

2. **Date of next visit:** ____

3. **Chief complaint at this time: (full diagnosis and concurrent conditions, if any)**
____
____

4. **Hospitalization:** ____

   Admission Date: ______________________ **Discharge Date:** _________________________

5. **Describe recent progress and type of treatment**: ______________________________________
____
____

6. **List all activity restrictions: (from date of last visit)** __________________________________
____
____

7. **Additional comments on patient's condition**: ____
____
____

8. **Date of house confinement :** ____
   (unable to work) **From** **-** **Through**

9. **Return to work date:** ____

Date ___________ **20** _______ **Physician's Signature**: _____________________________

Degree: __________________ **Address:** ____

Phone: ____