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: _____