



Operation Claim Form

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Name _____ Lodge # _____

Male Female Date of Birth _____ Policy # _____

Address _____

Date of Operation _____ Operation Performed _____

_____ CPT Code _____

Diagnosis after Operation _____ ICD 9 _____

Signature of Insured _____

The undersigned physician certifies under penalties of perjury, that the statements contained on this form are true and correct.

Doctor's Signature _____ Date _____

Printed Name of Doctor _____

Doctor's Address _____ Phone _____

Office Use Only

Approved _____

Disapproved _____

Deferred _____