

# Attending Physician Statement Request (A.P.S.)



**WEA**  
WORLDWIDE EXPATRIATE ASSOCIATION

Please submit this form and all related correspondent to:



**Int'l Healthcare Administrators, Inc.**  
135 San Lorenzo, PH 850  
Coral Gables, FL 33146 USA

Toll Free 1 (800) 595-1892  
Phone 1 (404) 591-2872  
Fax 1 (305) 443-9671  
Email [claims@weadirect.com](mailto:claims@weadirect.com)

## IMPORTANT: PLEASE READ INSTRUCTIONS CAREFULLY

The requested information is required to consider the following patient for medical coverage.

- Please complete all areas
- Use additional paper, if necessary

Name of Patient   
Date of Birth (MM/DD/YY)  Height  Weight

1. Diagnosis:

2. Date(s) Diagnosed: (MM/DD/YY)

3. Etiology

4. Present Medications  Dose:  mg  
Frequency and dates of usage:   MM/DD/YY  MM/DD/YY

5. Laboratory Findings (including X-Ray, ECG, BMR, Blood Chemistry Profile and Path Reports, etc.)

6. Progress (Surgeries, treatments, etc.):

7. Prognosis:

8. Date of Recovery: (MM/DD/YY)

9. Additional information which might affect patient's health:

Physician's Name

Date (MM/DD/YY)

Physician's Signature