



REPORT OF MEDICAL TREATMENT

Name of Patient	Case Number
-----------------	-------------

To the Patient's Attending Physician

The Illinois Department of Healthcare and Family Services (HFS) requests your assistance to determine the eligibility of the person named above.

Please complete this form and return it to the patient. Attach a copy of the admitting history and physical examination, test reports, physician's discharge summary and consultation reports (if applicable, doctor treatment notes for outpatient services) to the form and return it to the patient.

The patient named above was treated for the following medical condition:

Treatment Onset Date _____
mm/dd/yy

Was the patient admitted to a hospital? Yes No If yes, complete the following:

Hospital Admission Date _____ Hospital Discharge Date _____
mm/dd/yy mm/dd/yy

Does any part of the inpatient stay include rehabilitation or long term care services or care provided in any unit other than an acute care unit? Yes No If yes, date of transfer from acute care: _____
mm/dd/yy

Did the patient come to U.S. to receive medical care? Yes No Unknown

Signature of Attending Physician Date Telephone No.

Name of Attending Physician (PRINT) License Number