MOTION PICTURE INDUSTRY
PENSION & HEALTH PLANS™

Bone Stimulator Questionnaire
(Provider)

Participant: _____ **MPI ID:** _____

Patient: _____ **Date:** _____

The Plan covers services considered reasonable and necessary in connection with the diagnosis and treatment of any non-industrial illness or injury. The information provided below will assist us in expediting your request.

Diagnosis: _____

Indications for Stimulator (Clinical Details):

_____

_____

_____

_____

Fracture Repair Date:_____

X-Ray Findings (Dates): _____

_____

_____

Type of Stimulator Prescribed:_____

Your cooperation is appreciated.

Physician's Name: _____**License #**_____

Address: _____

Telephone: _____**FAX** _____

_____

Physician's Signature **Date**

Return completed form to the Medical Review Department:
MPIHP, P.O. Box 1999, Studio City, California 91614-0999