



## Diagnosis Update

Return completed form to:  
 BrickStreet Mutual Insurance  
 P.O. Box 3151  
 Charleston, WV 25332-3151

**THIS FORM IS INTENDED FOR USE BY THE PHYSICIAN OF RECORD TO UPDATE APPROPRIATE DIAGNOSTIC INFORMATION. SIGN, DATE THE FORM AND RETURN THE FORM.**

COMPLETE CLAIMANT AND PHYSICIAN INFORMATION. LIST ICD9-CM CODES IN ORDER OF SEVERITY WITH CORRESPONDING DESCRIPTIONS. SHOW CLINICAL FINDINGS UPON WHICH THE DIAGNOSIS IS BASED.

1. Claimant Name:	2. Claim Number:	3. Social Security Number	4. Date of Injury
5. Treating Physician Name and Address:		6. ICD9 - CM Diagnosis Numerical Code(s)	
		1. Primary:	
		2. Secondary:	
		3. Secondary:	
7. Physician's FEIN:		4. Secondary:	
8. Diagnosis Description:			
1. Primary:			
2. Secondary:			
3. Secondary:			
4. Secondary:			
9. Provide clinical findings on which current diagnosis is based and advise how the present condition relates to the compensable injury.			
10. Physician Signature:		11. Date:	