Attending Physician Statement

Complete and sign the form using BLUE or BLACK ink.

1. Patient Instructions – The Physician will complete Sections 2 through 9.
The Patient will complete Section 1. The Patient should also fill in their name at the top of Page 2.

The ***Patient*** is responsible for completing this section, and for **ensuring** that th**eir Attending Physician completes the remainder of this statement**. The Patient is responsible for paying any fees that may be charged for completion of this form by their physician. **If you have any questions, please call (866) 282-8495.**

(a) Control Number ______

(b) ______ / ______ / ______ / ______ / ______
Patient Name *(Last, First, Middle Initial)* Social Security Number Birth Date *(MM/DD/YYYY)* Height Weight(lb)

(c) Patient Gender ☐ Male ☐ Female

(d) ______
Patient Home Address – Required *(Current No., St., Town, State, Zip – no PO boxes)* ☐ Check if New

(e) Mailing Address, if different from Home address ______

(f) Patient Employer Name/City/State ______

(g) Patient Telephone Number ______ ☐ **Check if New**

(h) Job Title/Occupation ______

(i) Type of Claim: ☐ Short Term Disability ☐ Long Term Disability ☐ Waiver of Premium
☐ Long Term / Permanent Total Disability

2. Physician Instructions

The ***Attending Physician*** should **complete the items below,** based upon a **recent examination.** Attach additional documentation as needed. If you have any questions, please call **(866) 282-8495.**

Please complete form in its entirety and fax to (877) 693-7258. Page 2 MUST be completed before faxing.

3. Impairing Diagnosis & Treatment

(a) Primary Diagnosis ______ Primary ICD Code ______
Secondary Diagnosis ______ Secondary ICD Code ______
Other Diagnoses ______ Other ICD Codes ______

(b) Height ______ Weight ______ Date Measured *(MM/DD/YYYY)* ______

(c) If Pregnancy related, delivery or expected date ______ MM ______ DD ______ YYYY ______ Delivery Type: ☐ Vaginal ☐ Cesarean

(d) Primary Procedure ______ Primary CPT Code ______
Secondary Procedure ______ Secondary CPT Code ______
Other Procedures ______ Other CPT Codes ______

(e) Medication(s)/Dose/Frequency ______
______
Impairment from medication effects ______

(f) Is patient still under your care for this condition? ☐ Yes ☐ No, date service terminated ______ *(MM/DD/YYYY)*

(g) Treatment summary ______

(h) Office visit dates: First ______ *(MM/DD/YYYY)* Last ______ *(MM/DD/YYYY)* Next ______ *(MM/DD/YYYY)* Frequency of appointments ______

(i) Was patient recently hospitalized? ☐ No ☐ Yes Date hospitalized: Admit ______ *(MM/DD/YYYY)* Discharge ______ *(MM/DD/YYYY)*

(j) Hospital Name/City/State ______

4. History

(a) Symptoms: ______
______

(b) Date symptoms first appeared or accident happened .... MM ______ DD ______ YYYY ______

(c) Has patient ever had same or similar condition? ☐ No ☐ Yes, state when and describe.

(e) Is condition due to injury or sickness arising out of patient's employment? ☐ No ☐ Yes ☐ Unknown

(f) Other Treating Physicians
Name ______ Specialty ______ City ______ State ______
Name ______ Specialty ______ City ______ State ______

Patient Name *(Last, First Middle Initial)* **Required**

5. Abilities/Limitations

(a) **Patient is: Place remarks in item (d) below, if applicable.**

- Competent to endorse checks and direct the use of proceeds thereof ☐ Yes ☐ No ☐ Other/describe in (d)
- Able to work with others .... ☐ Yes ☐ No ☐ Other/describe in (d)
- Able to give supervision .... ☐ Yes ☐ No ☐ Other/describe in (d)
- Able to work cooperatively with others in group setting .... ☐ Yes ☐ No ☐ Other/describe in (d)
- Able to do? **Select one: Place remarks in item (d) below, if applicable.**
  - ☐ **Heavy work** activity. No limitations of functional capacity.
  - ☐ **Medium work** activity. Exerting 20-50 pounds of force occasionally, and/or 10-25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly
  - ☐ **Light work** activity. Exerting up to 20 pounds of force occasionally and/or up to 10 pounds of force frequently
  - ☐ **Sedentary work** activity – moderate limitation of functional capacity. Exerting up to 10 pounds of force occasionally. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time
  - ☐ **No ability to work.** Severe limitation of functional capacity; incapable of minimal activity
  - ☐ **Other.** Place remarks in item (d) below.

(b) **What medical restrictions/limitations are you placing on patient?** ***(Activities of Daily Living, Driving, Lifting, Pulling, Pushing, and Amounts, etc.)*** ____________________

____

____

- Number of Hours patient is capable of working in a day: ☐ 12 ☐ 10 ☐ 8 ☐ 6 ☐ 4 ☐ 2 ☐ 1 Hour/Day
- Number of Days per week patient is able to work: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 Days/Week
- Date you prescribed restriction on work activities .... Month ________ Day ________ Year ________
- How long are these restrictions/limitations in effect? ________ Days ________ Weeks ________ Months ☐ No Longer
- Estimated return to work date? ____________ *(MM/DD/YYYY)* modified duty ____________ *(MM/DD/YYYY)* full duty

(c) **Objective findings that substantiate impairment** *(current laboratory, physical and/or mental status examination, and other testing)*

____

(d) Other/Comments ____________________

____

6. Current Status

(a) Patient has .... ☐ Improved ☐ Stabilized ☐ Regressed ☐ Not Applicable

(b) Is there a medical contraindication for patient to participate in Vocational Rehabilitation (job training) programs?
☐ No ☐ Yes, please explain ____________________

(c) In your opinion, is your patient motivated to return to work? ____________________

7. Regulation Notice

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant.

California Residents: For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.

Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.

Pennsylvania Residents: 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.

8. Physician Certification

Attending Physician's Name *(**Print**)*	Degree	Specialty
Address *(No. Street, City, State, Zip Code)*	Telephone Number	Fax Number

9. Physician Signature

Signature	**Date** *(MM/DD/YYYY)*