



To prevent any unnecessary delays in processing your patient's claim, all questions must be answered.  
The treating provider must complete this form for consideration of disability benefits.

## 1 Member Information *(please print)*

FIRST NAME	LAST NAME		
<input type="text"/>	<input type="text"/>		

ADDRESS	CITY	STATE	ZIP CODE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

DATE OF BIRTH (MM/DD/YYYY)	SOCIAL SECURITY NUMBER	PREFERRED PHONE NUMBER
<input type="text"/>	<input type="text"/>	<input type="text"/>

ICD-10 CODE OR DSM5 DIAGNOSES AND DESCRIPTION	SYMPTOMS
<input type="text"/>	<input type="text"/>

HAS THE PATIENT EVER HAD THE SAME OR SIMILAR CONDITIONS?  YES  NO IF YES, PLEASE STATE WHEN AND DESCRIBE

IS/WAS THE PATIENT TOTALLY DISABLED ON A FULL-TIME CONSISTENT BASIS FROM PATIENT'S JOB?  YES  NO

IS/WAS THE PATIENT TOTALLY DISABLED ON A FULL-TIME CONSISTENT BASIS FROM ALL OTHER EMPLOYMENT/WORK?  YES  NO

EXACT DATES OF TOTAL DISABILITY (UNABLE TO WORK): FROM (MM/DD/YYYY)  THROUGH (MM/DD/YYYY)

EXPECTED RETURN TO WORK DATE (MM/DD/YYYY)

IS THERE AN INDICATION THAT THIS CONDITION IS ASSOCIATED WITH PHYSICAL INJURY OR SICKNESS ARISING OUT OF THE PATIENT'S EMPLOYMENT?  
 YES  NO

WHEN DID SYMPTOMS FIRST APPEAR OR THE ACCIDENT HAPPEN? (DISREGARD IF PREGNANCY)

IF PREGNANT, ESTIMATED DUE DATE (MM/DD/YYYY)	OR DATE OF DELIVERY (MM/DD/YYYY)	TYPE OF DELIVERY
<input type="text"/>	<input type="text"/>	<input type="text"/>

## 2 Other Treating Providers

NAME	PREFERRED PHONE NUMBER
<input type="text"/>	<input type="text"/>

ADDRESS	CITY	STATE	ZIP CODE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

NAME	PREFERRED PHONE NUMBER
<input type="text"/>	<input type="text"/>

ADDRESS	CITY	STATE	ZIP CODE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

NAME	PREFERRED PHONE NUMBER
<input type="text"/>	<input type="text"/>

ADDRESS	CITY	STATE	ZIP CODE
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

### 3 Treatment

PLEASE LIST ALL DATES OF TREATMENT AND THERAPY FOR THE LAST 12 MONTHS OR IF THIS IS A CONTINUATION OF DISABILITY, ALL TREATMENT DATES SINCE THE LAST FORM WAS COMPLETED (INCLUDE A COPY OF ALL TREATMENT AND THERAPY NOTES FOR DATES INDICATED).

DATES (MM/DD/YYYY)

TYPE OF TREATMENT/THERAPY

MEDICATION PRESCRIBED

TYPE OF SURGERY

DATE (MM/DD/YYYY)

CPT CODE

PSYCHOLOGICAL TESTING PERFORMED AND/OR OBJECTIVE FINDINGS (ATTACH COPY OF TEST RESULTS)

HAS THE PATIENT BEEN IN THE HOSPITAL?  YES  NO

IF YES, PLEASE GIVE DATES: FROM (MM/DD/YYYY)  THROUGH (MM/DD/YYYY)

HAS THE PATIENT BEEN CONFINED TO THEIR HOME?  YES  NO

IF YES, PLEASE GIVE DATES AND A BRIEF DESCRIPTION: FROM (MM/DD/YYYY)  THROUGH (MM/DD/YYYY)

HAS THE PATIENT REACHED MAXIMUM MEDICAL IMPROVEMENT WITH REGARD TO THIS DISABILITY?  YES  NO

IF NO, WHEN DO YOU ANTICIPATE THE PATIENT WILL REACH THE MAXIMUM MEDICAL IMPROVEMENT? (MM/DD/YYYY)

### 4 Current Status

HAS THE PATIENT

RECOVERED DATE (MM/DD/YYYY)   IMPROVED  UNCHANGED  RETROGRESSED

RESTRICTIONS AND/OR LIMITATIONS THAT PREVENT WORK PERFORMANCE ON A FULL-TIME, CONSISTENT BASIS:

### 5 Cardiac

FUNCTIONAL CAPACITY (AMERICAN HEART ASSOCIATION). BLOOD PRESSURE (SYSTOLIC/DIASTOLIC)

CLASS 1: NO LIMITATIONS  CLASS 2: SLIGHT LIMITATIONS  CLASS 3: MARKED LIMITATIONS  CLASS 4: COMPLETE LIMITATIONS

### 6 Physical Impairment (if applicable)

CLASS 1-3 RELATED TO PATIENT'S ABILITY TO WORK ON A FULL-TIME BASIS CONSISTENTLY.

CLASS 1: NO LIMITATION ON FUNCTIONAL CAPACITY; CAPABLE OF HEAVY PHYSICAL ACTIVITY. NO RESTRICTION. (0-10%)

CLASS 2: SLIGHT LIMITATION ON FUNCTIONAL CAPACITY; CAPABLE OF LIGHT MANUAL ACTIVITY. (15-30%)

CLASS 3: MODERATE LIMITATION OF FUNCTIONAL CAPACITY; CAPABLE OF CLERICAL/ADMINISTRATIVE (SEDENTARY) ACTIVITY. (35-55%)

CLASS 4: MARKED LIMITATION. (60-70%)

CLASS 5: SEVERE LIMITATION OF FUNCTIONAL CAPACITY; INCAPABLE OF MINIMAL (SEDENTARY) ACTIVITY. (75-100%)

**7 Mental/Nervous Impairment** (please circle degree of impairment)

	0 - 5% IMPAIRMENT	10 - 20% IMPAIRMENT	25 - 50% IMPAIRMENT	55 - 75% IMPAIRMENT	OVER 75% IMPAIRMENT
<b>INTELLIGENCE</b>	NORMAL OR BETTER	MILDLY IMPAIRED	MODERATELY MILD IMPAIRED	MODERATELY SEVERELY IMPAIRED	SEVERELY IMPAIRED
<b>THINKING</b>	NO DEFICIT	SLIGHT DEFICIT	MODERATE DEFICIT	MODERATE SEVERELY DEFICIT	SEVERE DEFICIT
<b>PERCEPTION</b>	NO DEFICIT	SLIGHT DEFICIT	MODERATE DEFICIT	MODERATE SEVERELY DEFICIT	SEVERE DEFICIT
<b>JUDGMENT</b>	NO DEFICIT	SLIGHT DEFICIT	MODERATE DEFICIT	MODERATE SEVERELY DEFICIT	SEVERE DEFICIT
<b>AFFECT</b>	NO PROBLEM	SLIGHT PROBLEM	MODERATE PROBLEM	MODERATE SEVERELY PROBLEM	SEVERE PROBLEM
<b>BEHAVIOR</b>	NO PROBLEM	SLIGHT PROBLEM	MODERATE PROBLEM	MODERATE SEVERELY PROBLEM	SEVERE PROBLEM

DO YOU BELIEVE THE PATIENT IS COMPETENT TO ENDORSE CHECKS AND DIRECT THE USE OF PROCEEDS THEREOF?  YES  NO

IF NO, PLEASE ADVISE:

NAME  PHONE NUMBER

ADDRESS  CITY  STATE  ZIP CODE

**8 Remarks**

**9 Provider Information**

FIRST NAME  LAST NAME

ADDRESS  CITY  STATE  ZIP CODE

PHONE NUMBER  FAX NUMBER  DEGREE

PROVIDER SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_