## PHYSICIAN REPORT FOR DISABILITY BENEFITS

(To prevent any unnecessary delays in processing your patient's claim, all questions must be answered.)

Member Name		Social Security #					
Date of birth:	If pregnant: EDDeliv	eryor	Delivery Date	Type of	pe of delivery		
CD-9	Diagnosis						
a. Symptoms:							
b. Has patient ever had	l same or similar con	dition?					
	Yes; please state wh						
c. Objective findings: F	Please forward the re	sults of any tests i	_	nosis listed abov	/e.		
Is/Was patient totally disable	d on a full-time consi	stent basis from:	Patient's job?  Any other work'	☐ Yes ?  ☐ Yes	□ No □ No		
Please furnish exact dates o	f total disability (unab	ele to work): From	(Co not complete for	through			
Please indicate the patient's							
ISTORY							
A. When did symptoms	s first appear or accid	ent happen: Date					
B. Is condition due to in	njury or sickness arisi	ing out of patient's	employment?				
□ No □	Yes; please explain:	•					
REATMENT							
	of trootmont (ainco n	roviously reported	if this is an undate	<b>.</b> 1.			
A. Please list all dates	or treatment (since pi	reviousiy reported	ii uiis is ari upuate	;) <u></u>			
B. Please indicate the	types of treatment (yo	ou may provide tre	eatment notes in pl	ace of dates and	types of treatment):		
1 - Medications pres	scribed:						
2 - Type of surgery:		2a - Date of s	surgery:	CPT co	de:		
3 - Therapy:							
C. Names and address	ses of other treating p	hysicians:					
		<del></del> -			<del> </del>		
D. Please indicate limit basis:	tations in activities an	nd how the condition	on prevents work p	erformance on a	full-time consistent		
E. Has patient been in	the hospital?	□No	☐Yes	From	through		
	:al:						
		m	through				
G. Has the patient read	ched maximum medio			•	] No □Yes		
H. Do you have a sign	•		·				

PROGNOSIS						
Has patient:	☐ Recovered; whe	n				
		restrictions; from		through		
	☐ Improved					
	Unchanged					
	☐ Retrogressed					
PHYSICAL IMPAIRMENT (if applied	c <b>able)</b> (Class 1-3 re	elate to patient's ability	to work on a full	time basis consistently.	.)	
☐ Class 1 - No limitation of funct☐ Class 2 - Slight limitation of fu☐ Class 3 - Moderate limitation ☐ Class 4 - Marked limitation. (6☐ Class 5 - Severe limitation of functions of functions.)	nctional capacity; c of functional capacit 60-70%)	apable of light manua ty; capable of clerical/	l activity. (15-30% administrative (se	) dentary) activity. (35-55	%)	
MENTAL/NERVOUS IMPAIRMEN	T (if applicable)					
☐ Class 1 - Patient is able to fun ☐ Class 2 - Patient is able to fun ☐ Class 3 - Patient is able to eng	nction in most stress gage in only limited s) engage in stress sit	s situations and engag stress situations and tuations or engage in	ge in most interpe engage in only lir interpersonal rela	rsonal relations. (slight l nited interpersonal relat tions. (marked limitation	ions. s)	
Do you believe the patient is compete	, , ,			*	] No	
If no, please advise name and addres						
in no, piease advise name and addres	3 Of fiext of Kill.					
CARDIAC (if applicable)						
(a) Functional capacity (American Heart Assn.)		☐ Class 1 (No limitation) ☐ Class 3 (Marked limitation)		☐ Class 2 (Slight limitation) ☐ Class 4 (Complete limitation)		
(b) Blood Pressure (last visit):			1			
, , , , , , , , , , , , , , , , , , , ,	Systolic		Diast	olic		
REHABILITATION						
A. Is patient working to your knowled	ge? ☐ Yes	□ No				
Is patient a suitable candidate for t	rial employment?	Patient's job? Any other wo		□ No □ No		
If yes, when could trial employmen	it begin?					
• •	_	e □ Part-	time			
Patient's job Any other work						
If no, please explain:			tii 110			
·						
REMARKS:	100.1					
Do not sign this form	if it was not filled out en	ntirely by your office. No inf	ormation should be co	mpleted by the patient.		
Attending Physician (please print)	Degree	Degree		Telephone		
Street Address	Cit	y or Town	State or Province	Zip Code		
Signature		Tax ID #		Date		
-						

