MESSA
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Physician/Psychologist Report For Disability Benefits

These benefits are paid under a policy underwritten by Life Insurance Company of North America.

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

Member information *(Please print)*

Member name	Social Security number	Date of birth *(mm/dd/yy)*
ICD-10 Code or DSM5 diagnoses and description:	**Symptoms:**	
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 Any other work? ☐ Yes ☐ No		
Please furnish exact dates of total disability (unable to work): From *(mm/dd/yy)* Through *(mm/dd/yy)*		
Please indicate the patient's expected return to work date *(mm/dd/yy)*		

History

If pregnant, estimated date of delivery *(mm/dd/yy)*	***Or*** date of delivery *(mm/dd/yy)*	Type of delivery
When did symptoms first appear, or the accident happen? (Disregard if pregnancy)		
Is there an indication that this condition is associated with physical injury or sickness arising out of the patient's employment? ☐ Yes ☐ No		
Names and address of other treating physicians:		
Name	Address	Phone
Name	Address	Phone
Name	Address	Phone

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)***.		
Type of treatment/therapy:		
Medication prescribed:		
Type of surgery:	Date of surgery:	CPT code:
Psychological testing performed and/or objective findings ***(attach copy of test results)***:		

Treatment *(cont.)*/restrictions

Please indicate limitations in activities and how the condition prevents work performance on a full-time consistent basis:

Has the patient been in the hospital?

☐ Yes ☐ No If **yes**, please give dates: From *(mm/dd/yy)* Through *(mm/dd/yy)*

Has the patient been confined to his/her home?

☐ Yes ☐ No If yes, please give dates: From (mm/dd/yy) Through (mm/dd/yy)

If yes, give a brief description why:

Has the patient reached maximum mental health improvement with regard to this disability? ☐ Yes ☐ No

If **no**, when do you anticipate the patient will reach the maximum metal health improvement? *(mm/dd/yy)*

Current status

Has the patient:

☐ Recovered Date (mm/dd/yy) Indicate restrictions:

☐ Improved Indicate restrictions:

☐ Unchanged Comments:

☐ Retrogressed Comments:

Physical impairment *(if applicable)*

(Class 1-3 relate to patient's ability to work on a full-time basis consistently.)

- ☐ Class 1: No limitation of functional capacity; capable of heavy physical activity. No restrictions. (0-10%)
- ☐ Class 2: Slight limitation of 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%)

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

Percentage of impairment	0% - 5%	10 - 20%	25% - 50%	55-75%	Over 75%
Intelligence	Normal or better	Mildly impaired	Moderately mildly impaired	Moderately severely impaired	Severely impaired
Thinking	No deficit	Slight deficit	Moderate deficit	Moderate severely deficit	Severe deficit
Perception	No deficit	Slight deficit	Moderate deficit	Moderate severely deficit	Severe deficit
Judgement	No deficit	Slight deficit	Moderate deficit	Moderate severely deficit	Severe deficit
Affect	No problem	Slight problem	Moderate problem	Moderate severely problem	Severe problem
Behavior	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: Address: Phone:

Cardiac

Functional capacity (American Heart Association)

- ☐ Class 1: No limitation.
- ☐ Class 2: Slight limitation.
- ☐ Class 3: Marked limitations.
- ☐ Class 4: Complete limitations.

Blood pressure (last visit):

_____ / _____

Systolic Diastolic

Remarks

Name of attending physician Degree

Phone Fax

Address City/Town State/Province Zip/Postal Code

Signature of physician Date