Disability Claim Form

PHYSICIAN FORM

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1. Name of Patient	2. SSN	3. Gender ☐ Male ☐ Female	4. DOB

History

a) Date symptoms first appeared or illness/accident happened	b) Date you advised patient to stop working	c) Has patient ever had same or similar condition? ☐ Yes ☐ No *If yes, attach description and dates*

d) Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown	e) Names and addresses of other treating physicians

Diagnosis

a) Date of last exam	b) Primary Diagnosis (including any complications)	c) ICD9 Code

d) Subjective Symptoms

e) Secondary Diagnosis (if applicable)	f) ICD9 Code	g) Subjective Symptoms

h) Objective findings (including current x-rays, EKG's, lab data, and any clinical findings)	i) If pregnant, expected delivery date	j) If delivered, actual delivery date

Treatment

a) Date of first visit for this illness or injury	b) Date of last visit	c) Date of next visit	d) Frequency of visits

e) Nature of Treatment (including surgery and medications prescribed, if any)

f) Is patient: ☐ Ambulatory ☐ Bed Confined ☐ House Confined ☐ Hospital Confined

g) Has patient been hospital confined? ☐ Yes ☐ No If yes, when?_____ to _____

Hospital Name:_____ Expected Recovery Date: _____

Hospital Address: _____

_____

_____

Additional Remarks:

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Cardiac (if applicable) ☐ Class 1 (no limitation)
a) Functional Capacity (American Heart Assn.) ☐ Class 2 (slight limitation) ☐ Class 3 (marked limitation) ☐ Class 4 (complete limitation)

b) Therapeutic Class (Activity Restriction)
☐ A. (none) ☐ B. (slight)
☐ C. (moderate) ☐ D. (marked)
☐ E. (complete)

c) Blood pressure last visit
_____
Systolic/Diastolic

Physical Impairment (*As defined in federal dictionary of occupational titles) **REMARKS:**
☐ Class 1 – No limitation of functional capacity; capable of heavy work* No restrictions (0-10%)
☐ Class 2 – Medium manual activity * (15-30%)
☐ Class 3 – Slight limitation of functional capacity; capable of light work * (35-55%)
☐ Class 4 – Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity (60-70%)
☐ Class 5 – Severe limitation of functional capacity; incapable of minimum (sedentary*) activity (75-100%)

Mental Impairment (if applicable)
a) Please define "stress" as it applies to this claimant b) What stress and problems in interpersonal relations has claimant had on the job?
☐ Class 1 – Patient is able to function under stress and engage in interpersonal relations (no limitations)
☐ Class 2 – Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
☐ Class 3 – Patient is able to engage in only limited stress situations and limited interpersonal relations (moderate limitations)
☐ Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
☐ Class 5 – Patient has significant loss of psychological, physiological, personal, and social adjustment (severe limitations)
Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? ☐ Yes ☐ No

REMARKS:

a) Does patient currently have limitations/restrictions?
Patient's Occupation: ☐ Yes ☐ No
Any Other Work: ☐ Yes ☐ No

b) Describe specific limitations and restrictions:

c) If employer can accommodate limitations and restrictions, is this patient able to return to work?
☐ Yes ☐ No ☐ Part-Time ☐ Full-Time

d) Date employment could begin

e) Under what conditions could this employee return to work? Please elaborate.

Are you, the physician, related to this patient? ☐ Yes ☐ No If yes, what is the relationship? _____

NOTE: If there are multiple unrelated diagnoses, please complete a second physician form with all relevant information.

ADDITIONAL REMARKS:

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance, is guilty of a crime and will be subject to civil fines and criminal penalties.

As the authorized physician, I acknowledge that the information and statements provided in this form are true and correct to the best of my knowledge. I certify that I have fully reviewed said issue and treatment pertaining to this claim with the patient and they have communicated to me that they fully understand.

Name (attending physician) *Please Print* Degree Phone Number

Street Address City State Zip Fax Number

Tax ID #:_____ Physician Signature:_____ Date: _____