Attending Physician Statement

Complete and sign the form using BLUE or BLACK ink.

Aetna Global Benefits®

Aetna Global Benefits
Attn: Disability Claims Processing
P.O. Box 30258
Tampa, FL 33630-3258
USA
Phone: 800-231-7729
(Outside USA – use AT&T access)
813-775-0190
(Direct or collect outside the USA)
Fax: 800-475-8751 (Toll Free)
813-775-0625 (Direct)

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 Pages 2 and 3.

The ***Patient*** is responsible for completing this section, and for **ensuring** that their **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 us at the above number.**

(a) Control Number _____

(b) Patient Name _____
(Last Name/Surname, First, Middle Initial)

_____ _____ _____ _____
U.S. Social Security/ ID # | Birth Date *(MM/DD/YYYY)* | Height | Weight(lb)

(c) Patient Gender ☐ Male ☐ Female

(d) Patient Home Address _____
Required *(Include Country)* ☐ Check if New

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

(f) Patient Employer Name/Address _____
(Include Country)

(g) Patient Telephone Number _____ ☐ **Check if New**
(Include Country Code)

(h) Job Title/Occupation _____

(i) Type of Claim: ☒ Long Term 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 us at the number above.**

Please complete form in its entirety and fax to the above number. Pages 2 and 3 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 _____ Last _____ Next _____ Frequency of appointments _____
(MM/DD/YYYY) *(MM/DD/YYYY)* *(MM/DD/YYYY)*

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

(j) Hospital Name _____
Name *City* *State* *Country*

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

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 _____ Country _____

Name _____ Specialty _____ City _____ State _____ Country _____

Name _____ Specialty _____ City _____ State _____ Country _____

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? _____

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

7. Regulation Notice

Any person who knowingly and with intent to injure, defraud or deceive 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.

Attention California Residents: For your protection, California law requires notice of the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Florida and Virginia Residents: Any person who knowingly and with intent to defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Attention Kentucky, Ohio and 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 may subject such person to criminal and civil penalties.

Attention Louisiana and West Virginia Residents: 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 may be subject to fines and confinement in prison.

Attention Maine and Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Attention New York 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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

8. Physician Certification

Attending Physician's Name ***(Print)***	Degree	Specialty
Address *(Include Country)*		
Telephone Number (Include Country Code)	Fax Number (Include Country Code)	
Are you a western trained physician? ☐ Yes ☐ No University/Institution *(Include Country)* _____		

9. Physician Signature

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