



Attending Physician Behavioral Health Statement

Complete and sign the form using BLUE or BLACK ink.

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 Page 2.

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 (877) 465-0424.

(a) Control Number _____

(b) _____ / _____ / _____ / _____
 Patient Name (Last, First, Middle Initial) Social Security Number Birth Date (MM/DD/YYYY) Height Weight(lb)

(c) Patient Gender Male Female

(d) _____
 Patient Home Address – Required (Current No., St., Town, State, Zip – no PO boxes) Check if New

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

(f) Patient Employer Name/City/State _____

(g) Patient Telephone Number _____ Check if New

(h) Job Title/Occupation _____

(i) Type of Claim: Short Term Disability Long Term Disability Waiver of Premium
 Long Term / Permanent Total 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 (877) 465-0424.

Please complete form in its entirety and fax to (866) 888-2308. Page 2 MUST be completed before faxing.

3. Impairing Diagnosis & Treatment

DSM IV-TR MULTIAXIAL DIAGNOSIS: (please indicate the primary impairing diagnosis at this time with an*)

AXIS I Primary Diagnosis _____ Secondary Diagnosis: _____ ICD-9 codes _____

AXIS II Primary Diagnosis _____ Secondary Diagnosis: _____ ICD-9 codes _____

AXIS III Primary Diagnosis _____ Secondary Diagnosis: _____ ICD-9 codes _____

Axis IV Primary Diagnosis _____ Secondary Diagnosis: _____

Axis V (GAF) CURRENT _____ High last year _____ Goal for return to work _____

(Please support GAF with objective findings in the symptom assessment section below)

SYMPTOM ASSESSMENT

(a) Subjective symptoms and complaints: _____

(b) Objective findings(Include mental status findings, testing results, rating scales, etc) _____

(c) Describe interpersonal stressors that impact ability to function _____

(d) Describe work stressors that impact ability to function _____

TREATMENT

(a) Medication(s) / Dose / Frequency: _____

(b) Impairment from medication effects _____
 Compliant with meds? _____

(c) Recent hospitalization? (where, when) _____

(d) Office visit dates: First _____ Last _____ Next _____ Frequency of appointments _____

(e) Compliant with tx? _____ Tx Goals _____

4. History

(a) Has patient ever had same or similar condition? No Yes, state when and describe _____

(b) Is condition due to injury or illness arising out of patient's employment? No Yes Unknown

(c) Name / Specialty / City / State of other Treating Physicians or Therapists

Name _____	Specialty _____	City _____	State _____
Name _____	Specialty _____	City _____	State _____
Name _____	Specialty _____	City _____	State _____

Patient Name (Last, First Middle Initial) Required

5. Abilities/Limitations

(a) Is this person capable of signing checks and directing the proceeds? _____

(b) Please check the appropriate response of the employee's ability to perform these job functions now.

	Unlimited Limitations	Limited	Marked	Unable To Perform
Follow work rules	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to work with others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to give supervision to others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to work cooperatively with others in group settings ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to maintain persistence to task	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to maintain attention and concentration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to work alone or in physical isolation from others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to interact with supervisors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to interact with public/customers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to use judgement and make decisions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to attain set standards and limits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Able to direct, control or plan activities of others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

(c) **Objective findings that substantiate impairment** (current laboratory, physical and/or mental status examination, and other testing):

(d) What psychological/medical restrictions/limitations are you placing on this patient? (Activities of Daily Living, Driving, 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? _____ No Longer
Days Weeks Months
- Estimated return to work date? _____ modified duty _____ full duty
(MM/DD/YYYY) (MM/DD/YYYY)

(e) Other/ Comments _____

6. Current Status

(a) Patient is/has Improved Unchanged Regressed

(b) Is there a medical contra-indication for patient to participate in Vocational Rehabilitation (job retraining) programs?

No Yes, please explain _____

(c) In your opinion, is your patient motivated to return to work? _____

7. Regulation Notice

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant.

California Residents: For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.

Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.

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 subjects such person to criminal and civil penalties.

8. Physician Certification

Attending Physician's Name (Print)	Degree	Specialty
Address (No. Street, City, State, Zip Code)	Telephone Number	Fax Number

9. Physician Signature

Signature	Date (MM/DD/YYYY)
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