Aetna® Attending Physician 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 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 (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. 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 _____ *(MM/DD/YYYY)* Last _____ *(MM/DD/YYYY)* Next _____ *(MM/DD/YYYY)* Frequency of appointments _____

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

(j) Hospital Name/City/State _____

Patient Name *(Last, 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 _____

Name _____ Specialty _____ City _____ State _____

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, 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 *(No. Street, City, State, Zip Code)*	Telephone Number	Fax Number

9. Physician Signature

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

Authorization For Aetna To Request Protected Health Information Necessary To Process A Disability Claim

Please Read The Following Carefully Before Completing Your Authorization. You May Refuse To Sign This Authorization (See *Section 6*).

1. Member Information (Information About Person For Whom This Authorization Is Requested.)

Last Name	First Name	Middle Initial

Member I.D. Number / Social Security Number	Birthdate (MM/DD/YYYY)	Daytime Telephone Number (include area code)

Street Address	City, State and Zip

2. This form requests a Member's unconditioned authorization for Aetna to ask another person or organization to disclose Member's Protected Health Information ("PHI") to Aetna for the purpose of processing my disability claim)

3. The specific PHI we are asking you to authorize Aetna to request is (This section completed by Aetna):

Any and all medical information including but not limited to information which relates to psychiatric or mental health, drug, substance abuse, and/or HIV Infection, including AIDS and related illnesses, concerning health care, advice and treatment (including but not limited to, medical records, histories, physical or diagnostic examinations reports and treatment notes).

4. By signing this form, you will authorize Aetna to request PHI described above from the following persons or organizations (or classes of persons or organizations):

Providers, including but not limited, to physicians, therapists, medical practitioners, health care professionals, diagnostic facilities, hospitals, clinics (including individuals or facilities which provide rehabilitation services or treatment).

5. Expiration of this Authorization (Select one):

When the following event occurs:
This Authorization is valid throughout the processing and any term of your disability claim.

Please review and complete important information on the reverse of this form.

6. **Important: Your signature below means that you understand and agree to the following:**

- You authorize Aetna to request from the persons or organizations named above, the PHI described above, for the purposes stated above.
- The information to be disclosed may be protected by law. Information disclosed under this authorization may be redisclosed and no longer protected by federal privacy regulations
- Failure to complete this form may prevent Aetna from receiving information necessary for the processing of your disability claim, which may result in a disability claim denial. Failure to complete this form will not however impact your receipt of medical services from providers
- You may revoke this Authorization at any time by notifying Aetna in writing, but please note that actions Aetna has taken before we received your revocation will still be valid under this authorization
- You may receive a copy of this form if you request it in writing from the address listed below

7. **Expiration of this Authorization (Select one):**

Signature of Member or Legal Representative	Date
Print Name	

If not the Member, describe your relationship to the Member:

☐ Caregiver
☐ Legal Representative
☐ Other: _____

If Member's legal representative is signing this Authorization, you must furnish a copy of the health care power of attorney, or other relevant document designating you as the representative.

Return this completed form to:

Attn:
Aetna Life Insurance Company
P.O. Box 14554
Lexington, Kentucky 40512- 4554

Telephone Number: **877-465-0424**
Fax Number: **866-888-2308**

Aetna™

Work History and Education Questionnaire

Instructions: Please print, answer all questions, date and sign the release

1. Employee Information

Name | Social Security Number

2. Education

Highest Level Achieved

Grade ☐ 1-8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED College ☐ 1 ☐ 2 ☐ 3 ☐ 4

Post Graduate Work

List Degrees, Majors

List Any Additional Training

List Any Certifications or Licenses

Military Services/Training

3. Work History

Current Job You Are Disabled From | Date Hired | Salary

Description of Your Job (e.g., Tasks/Functions Performed; Include: Equipment, Tools, Applications, Time Demands, Mental Demands, Stress Level)

List Those Duties You Now Cannot Perform

Supervision of Others ☐ Yes ☐ No

Number of Hours In Your Workday ☐ 8 ☐ 10 ☐ 12 Other _____

Other Job Titles Held:

In Your Work Day, How Much Time (Hours) Did You Spend:

A. Sitting	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ Continuously
B. Standing	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ Continuously
C. Walking	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ Continuously

On The Job You:	Occasionally	Frequently	Continually
1. Bend/Stoop	☐	☐	☐
2. Crawl	☐	☐	☐
3. Reach Above Shoulders	☐	☐	☐
4. Kneel	☐	☐	☐
5. Push/Pull	☐	☐	☐
6. Lift Up To 10 Pounds	☐	☐	☐
11-25 Pounds	☐	☐	☐
26-50 Pounds	☐	☐	☐
50 Pounds or More	☐	☐	☐

Do You Use Your Hands And/Or Feet For Repetitive Movements? (E.G. Operating Foot Controls)

Right Hand: ☐ Yes ☐ No Right Foot: ☐ Yes ☐ No

Left Hand: ☐ Yes ☐ No Left Foot: ☐ Yes ☐ No

Please provide complete work history information for the past 15 years (use additional paper if necessary)

4. Other Work History

Employer	Job Title	Employed From ________ To________	Salary

Description of your job

Training Received

Equipment, Tools, Applications, Time Demands, Mental Demands, Stress Level

Supervision of others as part of your job	Other Job Titles Held
☐ Yes ☐ No	

Employer	Job Title	Employed From ________ To________	Salary

Description of your job

Training Received

Equipment, Tools, Applications, Time Demands, Mental Demands, Stress Level

Supervision of others as part of your job	Other Job Titles Held
☐ Yes ☐ No	

Employer	Job Title	Employed From ________ To________	Salary

Description of your job

Training Received

Equipment, Tools, Applications, Time Demands, Mental Demands, Stress Level

Supervision of others as part of your job	Other Job Titles Held
☐ Yes ☐ No	

Please list your outside of work activities (e.g. Sports, Activities, Hobbies)

5. Additional Information

Before your Disability:

After your Disability:

6. Certification

I hereby certify that the foregoing statements and answers are complete and true to the best of my knowledge and belief.

Date ____________________ Signed Employee ____

7. Authorization

To my present employer and all previous employers:

I hereby authorize my present and past employers to provide Aetna or its representative with a description of all job-related duties and functions I performed while actively employed. I further authorize Aetna or its representative to release this information to vocational or clinical specialists it utilizes during the course of its administration of my disability claim. A copy of this authorization shall be as valid as the original.

Date ____________________ Signed Employee ____

Aetna Life Insurance Company
Telephone: 877-465-0424
Fax: 866-888-2308

Aetna™

Capabilities and Limitations Worksheet

Complete and sign the form using BLUE or BLACK ink.

Employee Name *(Last, First, Middle Initial)*	Social Security Number	Date of Birth (MM/DD/YYYY)

Gender ☐ Male ☐ Female	Job Title	Control Number

Current Diagnosis	Medications:

Indicate the percent of the day the following activities can be performed:

(Occasional 1-33% or .5-2.5 hrs. Frequent 34-66% or 2.6-5.0 hrs. Continuous 67-100% or 5.1-8 hrs. or Never)

	O	F	C	N
Climbing -	☐	☐	☐	☐
Crawling	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Lifting	☐	☐	☐	☐
Pulling	☐	☐	☐	☐
Pushing	☐	☐	☐	☐
Reaching above shoulder	☐	☐	☐	☐
Forward reaching	☐	☐	☐	☐
Carrying	☐	☐	☐	☐
Bending	☐	☐	☐	☐
Twisting	☐	☐	☐	☐

	O	F	C	N
Hand Grasping ___R___L	☐	☐	☐	☐
Firm Hand Grasping ___R___L	☐	☐	☐	☐
Fine Manipulation ___R___L	☐	☐	☐	☐
Gross Manipulation ___R___L	☐	☐	☐	☐
Repetitive Motion ___R___L	☐	☐	☐	☐
Sitting ___R___L	☐	☐	☐	☐
Standing ___R___L	☐	☐	☐	☐
Stooping ___R___L	☐	☐	☐	☐
Walking ___R___L	☐	☐	☐	☐
Other _____	☐	☐	☐	☐

Maximum weight patient is capable of lifting:

	O	F	C	N
1 - 5 lbs.	☐	☐	☐	☐
6 - 10 lbs.	☐	☐	☐	☐
11 - 20 lbs.	☐	☐	☐	☐
21 - 35 lbs.	☐	☐	☐	☐
36 - 50 lbs.	☐	☐	☐	☐
51 - 75 lbs.	☐	☐	☐	☐
75 - 100 lbs.	☐	☐	☐	☐
100 lbs. +	☐	☐	☐	☐

Approved Head and Neck Movements:

	Yes	No
Static Position	☐	☐
Frequent Flexing	☐	☐
Frequent Rotation	☐	☐

Can the Patient operate:

	Yes	No
A Motor Vehicle	☐	☐
Hazardous Machine	☐	☐
Power Tools	☐	☐

Limitations to:
Speaking _____hrs.
Vision (explain) _____
Depth Perception _____
Hearing (explain) _____

Exposure Limitations:	Yes	No		Yes	No
Heat	☐	☐	Dust	☐	☐
Cold	☐	☐	Fumes	☐	☐
Dampness	☐	☐	Chemicals	☐	☐
Noise	☐	☐	Radiation	☐	☐

Total # of hours patient capable of working per day: 12 ☐ 8 ☐ 6 ☐ 4 ☐ 2 ☐

Duration of restrictions: _____ Care Complete: Yes ☐ No ☐ Next Appointment: _____

Additional Comments:

_____

_____

_____

_____

_____ _____

Physician's Signature Date *(MM/DD/YYYY)*