EPIC | SPECIALTY BENEFITS

Short-Term Disability Claim Form

Attending Physician Statement

1. Patient's Name	2. Identification Number	3. Date of Birth
4. Date you first treated this patient	5. Date of most recent treatment	6. Date of next visit
7. Date sickness or injury began	8. Patient's Height _____	Patient's Weight _____
9. Diagnosis code (ICD-9 code)	10. Description	

11. Medication(s) prescribed

12. Is the condition primarily related to: (check all that apply) Employment MVA Illness Pregnancy Mental Disorder Injury Alcohol or Drug Dependence

13. If patient was hospitalized, please provide admit and discharge dates: Admit _____ Discharge _____

14. Has surgery been done? Yes No
If yes, date of surgery _____ CPT Code or Description of Procedure _____

15. Is this illness or injury intentionally self-inflicted or attempted suicide? Yes No
If yes, please provide details:

16. Is this illness or injury resulting from weight control or treatment of obesity not caused by an organic condition? Yes No
If yes, please describe your objective findings:

17. To the best of your knowledge, has the patient been diagnosed, received medical care, services, treatment, advice or recommendations for this condition prior to this disability onset? Yes No
If yes, please provide the name, address and telephone number of the referring physician.

18. Physical restrictions/limitations (as defined in the Federal Dictionary of Occupational Titles)

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%)

What are the patient's physical restrictions/limitations?

19. Mental impairments (if applicable)

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 or engage in 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 physiological, psychological, personal and social adjustment (severe limitations).

What are the patient's mental impairments?

For TOTAL DISABILITY, PARTIAL DISABILITY, or MATERNITY claims, please complete the appropriate section on the reverse side of this form.

TOTAL DISABILITY

20. What is the patient's current treatment plan (i.e. physical therapy, number of visits per week, length of session etc.)?

21. Date you advised your patient to stop working?

22. Are there any additional medical conditions or complications affecting your patient's recovery? Yes No
If yes, please explain.

23. What is the patient's expected return to work date?

24. Is the patient a candidate for partial disability? Yes No If yes, refer to PARTIAL DISABILITY section below.

PARTIAL DISABILITY

25. What is the patient's current treatment plan (i.e. physical therapy, number of visits per week, length of session etc.)?

26. Date you advised your patient to stop working?

27. Date you advised your patient to return to work part-time?

28. What is the number of days or hours the patient can resume part-time work?

29. What is the patient's expected return to work date on a full-time basis?

MATERNITY

30. Is this disability due to pregnancy? Yes No

31. Date of Last Menstrual Period:

32. If disability is prior to delivery, what are the complicating factors (be specific) and expected date of delivery?

33. Date you advised your patient to stop working?

34. What was the patient's expected date of delivery: _____ Actual date of delivery: _____

35. Type of delivery? Vaginal C-section

36. What is the patient's expected return to work date?

PHYSICIAN INFORMATION

Physician's Signature | Date

Physician Name (Please Print)

Physician Address | City | State | Zip

Physician Telephone Number

Physician Fax Number | Medical Records Department Fax Number

MAIL OR FAX FORM TO:

EPIC Specialty Benefits
Attention: Life & Disability Claims
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