P.O. Box 14192, Lexington, KY 40512-1192
Telephone: 800-638-4228 Facsimile: 859-264-4384 Email: myclaimdocs@sedgwick.com

**Attending Physician Statement**
To be completed by physician

**Patient's Name:** **Date of Birth:**

**Claim Number**: **Medical Due Date:**

1. Objective findings: HT: WT: BP: TEMP: PULSE: RESP:
2. Patient's Complaints: _____
3. Your Diagnosis: (list all disabling diagnoses including all ICD codes)
   Primary: ICD Code: _____ Description: _____
   Secondary: ICD Code: _____ Description: _____
4. Describe objective/clinical findings to warrant disability, including severity and duration based on the patient's presentation during office visits. _____
5. When was patient first diagnosed with this condition? _____/_____/_____
   List all medications, identify dates of new medications or dose adjustments: (attach list if necessary)

| Medication | Dose | Frequency | Duration | New Med | Adjusted Med | Date Adjusted |
|---|---|---|---|---|---|---|
| | | | | Yes ☐ No ☐ | Yes ☐ No ☐ | _____/_____/_____ |
| | | | | Yes ☐ No ☐ | Yes ☐ No ☐ | _____/_____/_____ |
| | | | | Yes ☐ No ☐ | Yes ☐ No ☐ | _____/_____/_____ |
| | | | | Yes ☐ No ☐ | Yes ☐ No ☐ | _____/_____/_____ |

6. Is this condition the result of an injury? Yes ☐ No ☐ Is this condition work related? Yes ☐ No ☐ If yes, provide date and description of event: _____
   List all co-morbid conditions: _____
7. If patient is pregnant, indicate estimated date of delivery _____/_____/_____
8. Is a C-Section planned? Yes ☐ No ☐ If yes, date scheduled: _____/_____/_____
9. Give all dates of treatments by you during this period of disability; also indicate date of follow up visit: _____
10. What is the prescribed treatment plan? (please provide specific details regarding treatment/therapy, attach notes if necessary):

11. Have there been any Emergency Room visits OR Hospitalizations during this current disability period? Yes ☐ No ☐
    If Yes: ☐ Emergency Room visit ☐ Hospitalization ☐ 23 hour admission
    Name and address of hospital or facility _____
    _____
    Date of admission: _____/_____/_____ Date of discharge: _____/_____/_____
    Indicate treatment provided: _____
12. Has any surgical procedure related to current disability been performed or is any anticipated? Yes ☐ No ☐
    List the name of the procedure: _____
    CPT code: _____
    Date of procedure: _____/_____/_____
13. Has patient been referred to other physician(s)/specialist? Yes ☐ No ☐ If yes, provide physician name, specialty, and telephone number. _____
    _____
14. List specific functional limitations of Activities of Daily Living (ADL's): _____
    _____
    _____
    _____
15. Has patient been given any driving restrictions for this disability period? Yes ☐ No ☐
    If yes please describe: _____
16. Based on your personal knowledge and treatment, how long has the patient been totally disabled by this sickness and prevented from working? From _____/_____/_____ to and including _____/_____/_____
17. Has the patient recovered sufficiently to return to work? Yes ☐ No ☐
    If yes, give the date the patient was able to return to work _____/_____/_____
    If no, in your opinion when, may work be resumed? (please do not use "indefinite", "unknown", "undetermined", etc.) If a date cannot be determined, please estimate in days, weeks or months, the total duration of disability. _____/_____/_____
    _____
18. Has the patient recovered sufficiently to return to restricted work? Yes ☐ No ☐
    If yes, indicate date restrictions begin: _____/_____/_____ date restrictions end: _____/_____/_____
    Restriction (s) required: _____
    _____
    _____

**Attach if relevant all office notes, history & physical, results of x-rays, laboratory tests, MRI Reports, etc.**

"The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

Telephone Number: _____ Physician Printed Name: _____

Fax Number: _____ Physician Specialty: _____

Date Completed: _____ Physician Signature: _____