Prudential

**The Prudential Insurance Company of America**
**Disability Management Services**
**P.O. Box 13480, Philadelphia, PA 19176**
**Tel: 800-842-1718 Fax: 877-889-4885**

# Microsoft Attending Physician Statement

## 1 Employee Information

Employer's Name

Control Number (required)

Employee First Name

MI

Last Name

Claim Number

Social Security Number

Date of Birth (MM DD YYYY)

Gender

☐ Female

☐ Male

I hereby authorize the release of information requested on this form by the below named physician for the purpose of claim processing.

Employee Signature X

Date (MM DD YYYY)

**The Employee is responsible for the completion of this form without expense to Prudential.**

## 2 To Be Completed by Attending Physician

**Instructions to the Health Care Provider:** Your patient has requested to take medical leave under Microsoft's Short Term Disability Policy, Microsoft's Long Term Disability Plan, and/or the Family and Medical Leave Act (FMLA). Please answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine coverage and may require us to contact you for more information. Please limit your responses to the condition(s) for which the employee is seeking leave. Do not provide information about genetic tests, as defined in 29 C.F.R. Section 1635(e), or the manifestation of disease or disorder in the employee's family members, 29 F.C.F. Section 1635(b). Please be sure to sign this form.

Clinical Diagnosis **ICD Code is Required**

Primary:

Secondary:

Secondary:

Pregnancy EDC (MM DD YYYY)

Actual Delivery Date (MM DD YYYY)

Date when significant loss of function occurred: (MM DD YYYY)

Do you feel the claimant is competent to endorse checks and direct the use of proceeds? ☐ Yes ☐ No

Return to Work Target Date (MM DD YYYY)

Full-Time ☐ Part-Time ☐ With Limitations (functions lost) ☐

Please describe Return to Work Plan and provide any corresponding Limitations:

Please describe any Medical Obstacles to Return to Work:

If you have not been provided with a job description, answer these questions based upon the employee's description of his/her job functions.

Is the employee unable to perform any of his/her job functions due to the condition: ☐ Yes ☐ No

If so, identify the job functions the employee is unable to perform:

Nature of Medical Impairment (i.e., loss of function):

Are there any Non-Medical Factors which have a significant impact on Functional Abilities (i.e., interpersonal, financial, family)?

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First Name | MI | Last Name | Claim Number

## 2 Attending Physician Information (Cont'd)

Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of the employee's medical condition?

☐ Yes ☐ No

If so, are the treatments or the reduced number of hours of work medically necessary? ☐ Yes ☐ No

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Estimate the part-time or reduced work schedule the employee needs, if any:

_____ hour(s) per day; _____ days per week from _____ through _____ .

**Check all that apply to this disability:**

| Work Related | Accident | Sickness | Maternity | Motor Vehicle Accident | If MVA, in what State did it occur? |
|---|---|---|---|---|---|
| ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | ☐ Yes ☐ No | |

**Other Treating Physicians or Consultants:**

First Name | Last Name

Specialty | Telephone Number

**Other Treating Physicians or Consultants**

First Name | Last Name

Specialty | Telephone Number

Date of Surgical Procedure (MM DD YYYY)

Relevant tests and surgical procedure (s) performed (please be specific):

Current Medications, Treatment, and Prognosis:

First Visit (MM DD YYYY) | Last Visit (MM DD YYYY) | Next Visit (MM DD YYYY)

Was Claimant hospital confined? ☐ Yes ☐ No

If yes, please provide name and address of hospital:

From (MM DD YYYY)

To (MM DD YYYY)

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First Name | MI | Last Name | Claim Number

## 3 Physician Information

First Name | MI | Last Name

Primary Telephone Number | Fax Number

Office Address | Suite

City | State | ZIP Code

Specialty

## 4 Fraud Notice

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

**I have read and understand the terms and requirements of the fraud warning and I certify the above statements are true.**

Physician Signature X _____ Date (MM DD YYYY)