Prudential

Group Disability Insurance
The Prudential Insurance Company of America
Disability Management Services
PO Box 13480, Philadelphia, PA 19176
Tel: (800) 842-1718 Fax: (877) 889-4885

Behavioral Health Capacity Evaluation

1 First Name | MI | Last Name | Claim Number

2 **To Be Completed By Attending Physician/Behavioral Health Clinician**

What date did you recommend the patient stop working due to their mental health/cognitive condition?

(MM DD YYYY)

Rationale for recommending leave from work:

Has a return to work been discussed with the patient? ☐ Yes ☐ No

Since the last visit with you, has the patient's condition: ☐ Improved ☐ Regressed ☐ Not changed?

Please explain:

What is the estimated return to work date? (MM DD YYYY) ☐ Full Time ☐ Part Time

Are they able to work now, but with accommodations or modifications? ☐ Yes ☐ No

If yes, please list them:

Has the patient conceptualized any of the following areas as barriers to returning to work?

Barrier	Yes	No	Additional Comments
Work demands	☐	☐	
Recent unfavorable work evaluation	☐	☐	
Conflict with supervisor/coworker	☐	☐	
Anticipation of relapse	☐	☐	
Dissatisfaction with job	☐	☐	
Family stressors	☐	☐	
Financial strain	☐	☐	
Other:	☐	☐	

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	Clinical Diagnosis ICD Code	Description	Onset Date
Primary			
Secondary			
Other			

Able to recall four unrelated words after 5 minutes ☐ Yes ☐ No

Able to perform five operations of serial 7's or 3's? ☐ Yes ☐ No

Other testing results

Are they able to express themselves and their current situation and respond to questions appropriately? ☐ Yes ☐ No

If no, please provide details/examples of how they have difficulty with conversation.

Does the employee have a significant impairment in any other area of cognitive or psychological function not addressed in the questions above? ☐ Yes ☐ No

If yes, please identify the impairment.

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Please circle selections/responses

ABLE TO PERFORM ADLS ☐ Yes ☐ No	If you answered no, provide examples.				
APPEARANCE	Well Groomed		Disheveled	Inconsistent	Bizarre
MOTOR ACTIVITY	Normal	Retarded	Agitated		
AFFECT	Appropriate	Sad	Worried	Flat	
	Blunted	Labile	Expansive	Constricted	
MOOD	Normal	Anxious	Depressed	Labile	
SPEECH	Normal	Soft Loud	Pressured	Delayed	Slurred
THOUGH PROCESS	Intact	Loose	Circumstantial	Tangential	Flight of ideas
HALLUCINATIONS	None	Visual	Auditory	Both	
DELUSIONS	None	Paranoid	Persecutory	Grandiose	
ORIENTATION	Fully Oriented	Disoriented			
JUDGMENT	Intact	Impulsive	Fair	Poor	
AT RISK BEHAVIORS	**Suicidal** ☐ Yes ☐ No	With plan	Without plan	With intent	Without intent
	Homicidal ☐ Yes ☐ No	With plan	Without plan	With intent	Without intent

Please provide additional details for any abnormalities indicated above including specific observations.

Please describe the restrictions and limitations identified in your recent exams and provide the exam date.

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Is the patient able to clean and maintain their residence? ☐ Yes ☐ No

Is the patient able to routinely shop? ☐ Yes ☐ No

Is the patient able to pay bills? ☐ Yes ☐ No

Is the patient driving regularly? ☐ Yes ☐ No

Have these abilities changed since they stopped working? ☐ Yes ☐ No

Has your patient participated in or been referred to an intensive outpatient program (IOP) or partial hospitalization program (PHP)? ☐ Yes ☐ No

Admit date (MM DD YYYY) Discharge date (MM DD YYYY)

Where:

Has the patient been admitted for inpatient care since going out of work? ☐ Yes ☐ No

Admit date (MM DD YYYY) Discharge date (MM DD YYYY)

Where:

If not, has this been recommended? ☐ Yes ☐ No

If not, why?

Medication name	Dosage	Frequency	Date started	Date changed	Prescribing Doctor

Are there any medication side effects? ☐ Yes ☐ No

If yes, please describe

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3 **Attending Physician/Behavioral Health Clinician Certification**

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 as 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.

First Name | MI | Last Name

Specialty

Primary Telephone Number | Fax Number

Provider's Signature: _____ Date completed (MM DD YYYY)

Please FAX this completed document to (877) 889-4885. Please make sure the claimant's name and claim number are entered at the top of each page. Thank you.

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