Prudential

Group Disability Insurance

The Prudential Insurance Company of America
Disability Management Services
PO Box 13480, Philadelphia, PA 19176
Tel: 877-367-7781 Fax: 877-889-4885
www.prudential.com/forphysicians

Certification of Health Care Provider for Employee's Serious Health Condition for Disability and Medical Leave

1

First Name | MI | Last Name | Claim Number

Social Security Number | Date of Birth (MM DD YYYY) | Employee Phone Number | Mobile Phone

Gender ☐ Female ☐ Male

Employer's Name | Control Number (required)

For disability purposes, have this certification completed by a doctor as defined in the group contract.
By the signature below, I give permission to my provider to clarify information regarding the clinical reason for me to take time from work as described within this document. I understand that the required information, if not provided by the due date, may result in my leave not being approved or other action by my employer.

X _____ Date Signed (MM DD YYYY)

Employee Signature (Explain relationship if other than patient.)

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For disability purposes, this certification must be completed by a doctor as defined in the group contract. All medical facts must be provided by the treating provider. Documentation must be provided in English or be accompanied by a translation of medical facts. Please attach written statements to this form if more space is needed. Your signature is required on the last page of this form.

Your patient has requested Medical Leave and his/her company's disability program. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency and length of a condition, treatments, 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 "As Needed" will not be sufficient to determine medical leave or disability payment coverage. Without sufficient medical fact, this form will be returned as incomplete.

Which of the following best describe your patient's medical condition?

☐ Injury — Motor Vehicle Accident (MVA) ☐ Yes ☐ No — If MVA, in what state did it occur?

☐ Illness

☐ Pregnancy ☐ Estimated Delivery Date ☐ Actual Delivery Date (MM DD YYYY)

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

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ Yes ☐ No

If yes, provide name and address of hospital:

Date Admitted (MM DD YYYY)

Date Discharged (MM DD YYYY)

Dates you treated the patient for this condition: First Visit (MM DD YYYY) | Last Visit (MM DD YYYY) | Next Visit (MM DD YYYY)

Are there any other treating providers or consultants involved in your patient's care? ☐ Yes ☐ No

Other Treating Providers or Consultants: If there is more than one Other Treating Provider or Consultant, please use an additional page to provide their information.

First Name | Last Name

Specialty | Telephone Number

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Failure to complete this section will not impact your patient's rights for medical leave. All information provided will be taken into consideration for the disability benefit and medical leave purposes.

Clinical Diagnosis **ICD Code is Required**

Primary:

Secondary:

Secondary:

If patient had surgery, please provide the date and procedure details on the line below.

Date of Surgical Procedure (MM DD YYYY)

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

In the space provided below, please describe relevant medical facts, if any, related to the condition for which the employee seeks leave from work (i.e., diagnosis, pregnancy complications, symptoms, or any regimen of continuing treatment such as the use of specialized equipment)

Relevant tests and surgical procedure(s) other than listed above – Provide specific details, including dates of all procedures

Was medication, other than over-the-counter medication prescribed? ☐ Yes ☐ No If yes, please provide medications prescribed.

Current treatment plan and prognosis

Were you provided with a job description for your patient, or did you discuss the essential functions of their job? ☐ Yes ☐ No

During their absence, what job function(s) is/was your patient unable to perform due to this medical condition?

Are there any non-medical factors which have a significant impact on functional abilities (i.e., interpersonal, financial, family)?

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Return To Work Details

In your medical opinion does the patient have:
Full-time work capacity (8 hours, 5 days per week)? ☐ Yes ☐ No If yes, what is the RTW Date (MMDDYY)

Part-time transitional work capacity?
If yes, what are the start and end dates ☐ Yes ☐ No If yes, _____ hours, _____ days per week

Start Date (MMDDYY) End Date (MMDDYY)

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INTERMITTENT ABSENCE DETAILS For approximately how long will your patient need the intermittent "time away from work"? An estimate must be provided. Provide an estimate of the frequency and the duration of related incapacity or scheduled appointments that the patient may have.

Start date (MM DD YYYY) End date (MM DD YYYY)

1. Will the patient require follow-up treatments, including any time for recovery? ☐ Yes ☐ No If yes, please provide the following details.

- Estimate treatment schedule. If any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period.

- Explain the care needed by the patient, and why such care is medically necessary.

2. Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal daily activity? ☐ Yes ☐ No
If yes, please provide the following details.

- Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have.

FREQUENCY: ____ # Times per ○ week, or ○ month, or ○ year **(CHECK ONLY 1)**
DURATION: ____ # hour(s) or ____ # full day(s) per episode

Example:
FREQUENCY: 3 # Times per ○ week, or ☒ month, or ○ year **(CHECK ONLY 1)**
DURATION: ____ # hour(s) or 2 # full day(s) per episode

Does the patient need care during these flare-ups? ☐ Yes ☐ No If yes, please provide the following details.

- Explain the care needed by the patient, and why such care is medically necessary.

REMINDER: Include necessary time for travel. "Lifetime," "Unknown," or "As Needed," or the like will be returned as incomplete information.

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First Name | MI | Last Name | Claim Number

Provider First Name | Provider Last Name

Provider Area of Specialty (i.e., General Practitioner, Oncologist, Obstetrician)

Note: This information is not required to certify leave under the federal FMLA, but may be required to certify leave under specific State leave laws.

Provider License Number or NPI Number | State or country (if not U.S.A) in which provider is licensed to practice

Office Phone Number | Office Fax Number

Office Address | Suite

City | State | ZIP Code

Please Read

GINA Disclaimer: 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, 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.

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 notice and disclaimer. I certify the above statements are true.

I understand for disability purposes, this certification must be completed by a doctor as defined in the group contract.

X

Treating Provider

Date Signed (MM DD YYYY)