

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 Serious Health Condition

Employee Information		
First Name	MI Last Name	Claim Number
Social Security Number Date of Birth (MM I	Employee Phone Number	Mobile Number
Employer's Name	Col	ntrol Number (required)
By the signature below, I give permission to my health care provi	er to clarify information regarding the clinical reason for me	e to take time from work as described within this
document. I understand that the required information, if not provi		
	Date Signed (MM DD YYYY)	
X		
Employee Signature (Explain relationship if other than patient.		
Instructions to the HEALTH CARE PROVIDER		
All medical facts must be provided by the treating physic	ian. Documentation must be provided in English or	be accompanied by a translation of
medical facts. Please attach written statements to this f		
Your patient has requested leave. Answer, fully and completely, treatments, etc. Your answer should be your best estimate based		
condition for which the employee is seeking absence from work.	Be as specific as you can; terms such as "Lifetime," "Unk	
determine coverage. Without sufficient medical facts, this form v	vill be returned as incomplete.	
Which of the following best describes your patient's me	lical condition?	
Injury Illness Pregnancy		
What is the approximate date the condition commenced?	(MM DD YYYY)	
What is the expected duration the condition will last?	(MM DD YYYY)	
First Visit	(MM DD YYYY) Last Visit (MM DD YYYY)	Next Visit (MM DD YYYY)
Dates you treated the patient for this condition:		
Are there any other treating physicians or consultants involved	in your notice t's care? Ves No	
Are there any other treating physicians or consultants involved	in your patient's care? Yes No	
Physician First Name	Physician Last Name	
Physician Area of Specialty (i.e., General Practitioner, Oncologi	t, Obstetrician)	
Office Phone Number Office Fax	Number	
Office Address	Suite	
City	State ZIP Code	
		Continued on Page 2



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Instructions to the HEALTH CARE PROVIDER (cont'd) Please indicate which of the below apply to your patient's condition (Check all that apply) Pregnancy Incapacity due to pregnancy or prenatal care			1
Pregnancy Incapacity due to pregnancy or prenatal care Estimated Delivery Date (www oo yww)		_	_
Pregnancy Incapacity due to pregnancy or prenatal care Estimated Delivery Date (MM DO YYYY) Inpatient Care Overnight stay in hospital, hospice or residential medical care facility Date of admission: Date Admitted (MM DO YYYY) Incapacity of more than 3 days and continuing treatment (Check all that apply) Incapacity of More than 3 days and continuing treatment (Check all that apply) Incapacity of More than 3 days and continuing treatment (Check all that apply) Incapacity of More than 3 days and continuing treatment (referral to a specialist, Rx Medications, Therapy, etc.) Incapacity of More than 3 days and continuing treatment (referral to a specialist, Rx Medications, Therapy, etc.) Incapacity of More than 3 days and continuing treatment (referral to a specialist, Rx Medications, Therapy, etc.) Incapacity of More than 3 days and continuing treatment (referral to a specialist, Rx Medications, Therapy, etc.) Incapacity of More than 3 days and continuing treatment (referral to a specialist, Rx Medications, Therapy, etc.) Incapacity of More than 3 days and continuing treatment for such incapacity due to a chronic serious health condition which: Premanent (Long-term Conditions) A period of incapacity or treatment for such incapacity due to a chronic serious health condition which: Permanent/Long-term Conditions A period of incapacity Permanent/Long-term Conditions A period of incapacity or treatment (All of the below bullets must be met) Permanent/Long-term Conditions A period of incapacity or treatment (All of the below bullets must be met) Permanent/Long-term Conditions A period of incapacity or treatment (All of the below bullets must be met) Permanent/Long-term Conditions A period of incapacity or treatment (All of the below bullets must be met) Permanent/Long-term Conditions and treatment (All of the below bullets must be met) A conditions requiring multiple treatments (All of the below bullets must be met) Permanent/Long-term Conditions (All of the below bullets must be met) A period of incapacity or treatmen			
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Does your patient's condition limit at least one of the essential functions of their job? Yes No			
If so, identify the job functions the employee is unable to perform:			

Continued on Page 3





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HEALTH CARE	PROVIDER																	
Physician First Nam			Ph	ysician La	ast Name				,									
Physician Area of Sp	ecialty (i.e., Gen	eral Practitioner	Oncologist, Obste	etrician)														
									-									
Note: This informa	ion is not requ	ired to certify	eave under the f	ederal F	MLA, but n	nay be r	equired	to ce	tify l	eave	und	ler sp	ecific	Stat	e leav	e law	S.	
Provider License Nun	ber or NPI Num	ber S	tate or country (if	not U.S.A) in which p	rovider is	license	d to pr	actice									
Office Phone Number			Office Fax Number															
Office Address						5	uite		,									
City			St	ate	ZIP C	ode			•									
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