



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 Serious Health Condition

1 Employee Information

First Name <input type="text"/>	MI <input type="text"/>	Last Name <input type="text"/>	Claim Number <input type="text"/>
Social Security Number <input type="text"/>	Date of Birth (MM DD YYYY) <input type="text"/>	Employee Phone Number <input type="text"/>	Mobile Number <input type="text"/>
Employer's Name <input type="text"/>			Control Number (required) <input type="text"/>

By the signature below, I give permission to my health care 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 _____
Employee Signature (Explain relationship if other than patient.)

Date Signed (MM DD YYYY)

2 Instructions to the HEALTH CARE PROVIDER

All medical facts must be provided by the treating physician. 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 leave. Answer, fully and completely, all applicable parts below. 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. Limit your responses to the condition for which the employee is seeking absence from work. Be as specific as you can; terms such as "Lifetime," "Unknown," or "As Needed" may not be sufficient to determine coverage. Without sufficient medical facts, this form will be returned as incomplete.

Which of the following best describes your patient's medical 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)

Dates you treated the patient for this condition:

First Visit (MM DD YYYY)	Last Visit (MM DD YYYY)	Next Visit (MM DD YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>

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

Physician First Name <input type="text"/>	Physician Last Name <input type="text"/>
--	---

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

Office Phone Number <input type="text"/>	Office Fax Number <input type="text"/>
---	---

Office Address <input type="text"/>	Suite <input type="text"/>
--	-------------------------------

City <input type="text"/>	State <input type="text"/>	ZIP Code <input type="text"/>
------------------------------	-------------------------------	----------------------------------

Continued on Page 2





Prudential

Disability Management Services
Tel: 877-367-7781 Fax: 877-889-4885
www.prudential.com/forphysicians

First Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

MI

--

Last Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Claim Number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

2 Instructions to the HEALTH CARE PROVIDER (cont'd)

Please indicate which of the below apply to your patient's condition (Check all that apply)

<input type="checkbox"/>	Pregnancy Incapacity due to pregnancy or prenatal care Estimated Delivery Date (MM DD YYYY) <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> Actual Delivery Date (MM DD YYYY) <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																		
<input type="checkbox"/>	Inpatient Care Overnight stay in hospital, hospice or residential medical care facility Date of admission: <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> Date Admitted (MM DD YYYY) <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table> Date Discharged (MM DD YYYY) <table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>																		
<input type="checkbox"/>	Incapacity of more than 3 days and continuing treatment (Check all that apply) Incapacity of More than 3 days and: <input type="checkbox"/> 2 visits to a Health Care Provider within 30 days; or <input type="checkbox"/> 1 visit to a Health Care Provider and a regimen of treatment (referral to a specialist, Rx Medications, Therapy, etc.)																		
<input type="checkbox"/>	Chronic Serious Health Condition (All of the below bullets must be met) Any period of incapacity or treatment for such incapacity due to a chronic serious health condition which: <ul style="list-style-type: none">• Requires 2 office visits per year• Continues over an extended period of time• May cause episodic incapacity																		
<input type="checkbox"/>	Permanent/Long-term Conditions A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. Must be under supervision of a Health Care Provider, but does not require active treatment.																		
<input type="checkbox"/>	Conditions requiring multiple treatments (All of the below bullets must be met) <ul style="list-style-type: none">• Restorative Surgery after an accident or injury• A condition that would likely result in a period of incapacity of more than 3 consecutive calendar days in the absence of medical intervention.																		
<input type="checkbox"/>	Other (please describe the condition below)																		

Job Restriction Details:

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

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





First Name

MI

Last Name

Claim Number

3 Absence From Work Details

Please list only dates/times it is medically necessary for the patient to be absent from work due to this medical condition. The patient's medical history and your knowledge of the condition should be used to provide an estimated absence need. If the end date is unknown, provide the next office visit for reevaluation. Forms marked as "Lifetime," "Unknown," or "As Needed" will be returned as incomplete.

Which of the following best describes the absence pattern? (check the appropriate absence patterns and complete the subsequent dates for which you are certifying)

☐ **Single Continuous Absence Period** Start date (MM DD YYYY) End date (MM DD YYYY)

Please list any subsequent dates the employee may need to be absent along with the continuous time above

(MM DD YYYY) (MM DD YYYY) (MM DD YYYY)

☐ **Intermittent Absence**

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.

Continued on Page 4





Prudential

Disability Management Services
Tel: 877-367-7781 Fax: 877-889-4885
www.prudential.com/forphysicians

First Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

MI

--

Last Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Claim Number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

4 HEALTH CARE PROVIDER

Physician First Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Physician Last Name

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Physician 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 all of the terms and conditions of the above fraud notice and disclaimer and also certify that all of the above statements on this form are true.

X

Treating Health Care Provider

Date Signed (MM DD YYYY)

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

