

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

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

X Date Signad (Mx op vvv) For disability purposes, this certification must be provided in the group contract. All medical facts must be provided by a doctor as defined in the group contract. All medical facts must be provided by treating provider. Documentation must be provided in English or be accompanied by a translation of medical facts. Please attach written statem this form if more space is needed. Your signature is required on the last page of this form. Your patient has requested Modical Leave and his/her comparys (dishifty regram. Answer, fully and completely, all applicable parts. Several questions seek at 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 e the patient dest specific as your car, terms such as "Lifetime," "Linknown," or "As Needed" will not be sufficient to determine medical leave or disability pay 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? Injury Motor Vehicle Accident (MVA) Yes No If MVA, in what state did it occur? 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 Obscharged (Mu to vvv) Date Discharged (Mu to vvv) Date Vehicle Accident (Mu to vvv) Date sport treating Providers or consultants,						MI		Last N	lame										Clair	m Nur	mber		
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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		-			lved ir	n your p	ati	ent's d	care?		Yes		No										
Specialty Telephone Number	Are there any other trea	ating providers o	or consultan		lved ir	n your p	oati	ent's d	are?		Yes		No										
	Are there any other treating Provid	ating providers o lers or Consult	or consultan tants:	ts invo						onal p		provi		r infor	matic	on.							
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Certification of Health Care Provider for Employee's Serious Health Condition for Disability and Medical Leave

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

First Name		MI	Last Name		Claim Number
	blete this section will not impact y for the disability benefit and medi			l information provide	d will be taken into
Clinical Diagnosis Primary: Secondary:		, provide tł	had surgery, please le date and procedure the line below.	Date	e of Surgical Procedure (MM DD YYYY)
Secondary:		Do you fe	el 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

Current medications, treatment, and prognosis

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
Return To Work Details					
Return To Work Date (MM DD YYYY)		Full Time	Part Time	Work Limitations	(functions lost)
Were you provided with a job description for your patient, or o	did you d	iscuss the essential func	tions of their job?	Yes No	
During their absence, what job function(s) is/was your patient	t unable 1	to perform due to this me	edical condition?		

Describe the return to work plan, and provide any corresponding limitations.

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 all that apply)

S	ingle Continuous Absence	Short-term Episodic Absences	Chronic or Lifelong Absences (M	linimum of 2 office visits per year required)
Please	describe the expected absen	ce from work needed:		
Si	ngle Continuous Absence Period	Start Date (MM DD YYYY)	End D	Date (MM DD YYYY)
	reseeable (i.e., appointments, ther			
INTERI	MITTENT ABSENCE DETAILS: P	rovide an estimate of the frequency ar	nd the length of related incapacity	or scheduled appointments that the patient may have.
			Example	
FREQUE	NCY:Times per wee	k, or month, or year (check on	<pre>ly 1) FREQUENCY: _3Times pe</pre>	er \bigcirc week, or $ig X$ month, or \bigcirc year (check only 1)
LENGTH	minute(s), hour(s)	orfull day(s) per episode	LENGTH: minute(s),	2 hour(s) orfull day(s) per episode
	•	or travel. "Lifetime," "Unknown," ent need the intermittent "time away		I be returned as incomplete information. timate must be provided.
Start D	ate (MM DD YYYY)	End Date (MM DD Y	YYY)	
REMIN	IDER: Forms marked as "Lifetin	ne," "Unknown," or "As Needed" v	will be returned as incomplete	
GL.2010.195	Ed. 01/2024	* 6 9 1 6		Continued on Page 4. Page 3 of 4



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First Name	MI Last Name		Claim Number
Provider First Name	Provider Last Name		
Provider Area of Specialty (i.e., General Practitie	ner, Oncologist, Obstetrician)		
Note: This information is not required to ce Provider License Number or NPI Number	State or country (if not U.S.A) in whic		nuer specific State feave faws.
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 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.

	Date Signed (MM DD YYYY)
Х	
Treating Provider	

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22405910 Page 4 of 4