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 Family Member's Serious Health Condition

1 Employee/Caregiver Information

First Name | **MI** | **Last Name** | **Claim Number**

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

Employer's Name | **Control Number (required)**

By the signature below, I attest that the information in this document is intended to support my need to be absent from work in order to provide care for my family member as outlined by the treating physician.

Date Signed (MM DD YYYY)

X _____
Employee Signature

2 Patient/Family Member Information

Patient First Name | MI | Last Name

Date of Birth (MM DD YYYY)

Relationship to employee: Please check ONLY one.

Partner	**Child**	**Parent**	**Other**
☐ Marital Spouse*	☐ Minor (Under age 18)	☐ Parent	☐ Describe relationship on the line provided below.
☐ Domestic Partner	☐ Adult – NOT Disabled	☐ Parent-in-Law	
☐ Civil Union Partner	☐ Adult – With Disability**	☐ Other: (Describe relevant facts.)	
☐ Other: (Describe relevant facts.)	☐ Other: (Describe relevant facts.)		

_____

* "Spouse" means a person to whom you are lawfully married.

****Disabled Adult Child/ADA Qualified:** Individual age 18 or older and incapable of self care because of a mental or physical disability that substantially limits 3 or more ADLs or IADLs.

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First Name	MI	Last Name	Claim Number

3 Instructions for 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.

The employee listed above has requested leave to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or length of a condition or treatment. 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 fact, this form will be returned as incomplete.

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

☐ Injury ☐ Illness ☐ Pregnancy ☐ Other

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

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)

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, Oncologist, Obstetrician)

Office Phone Number

Office Fax Number

Office Address

Suite

City

State

ZIP Code

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3 Instructions for the HEALTH CARE PROVIDER (cont'd)

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

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)

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

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

☐ **Pregnancy**
Incapacity due to pregnancy or prenatal care
Estimated Delivery Date (MM DD YYYY) Actual Delivery Date (MM DD YYYY)

☐ **Inpatient Care**
Overnight stay in hospital, hospice or residential medical care facility
Date of admission:
Date Admitted (MM DD YYYY) Date Discharged (MM DD YYYY)

☐ **Incapacity of more than 3 days and continuing treatment (Check all that apply)**
Incapacity of More than 3 days and:
- ☐ 2 visits to a Health Care Provider within 30 days; or
- ☐ 1 visit to a Health Care Provider and a regimen of treatment (referral to a specialist, Rx Medications, Therapy, etc.)

☐ **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:
- Requires 2 office visits per year
- Continues over an extended period of time
- May cause episodic incapacity

☐ **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.

☐ **Conditions requiring multiple treatments (All of the below bullets must be met)**
- 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.

☐ **Other** *(please describe the condition below)*

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3 Instructions for the HEALTH CARE PROVIDER (cont'd)

As a result of the patient's serious health condition, they need assistance with: (please check all that apply)**:**

- ☐ Ambulation Assistance
- ☐ Bathing
- ☐ Cleaning
- ☐ Cooking
- ☐ Coordinating Medical Care
- ☐ Dressing
- ☐ Eating
- ☐ Grooming/Hygiene
- ☐ Maintaining a residence
- ☐ Medication Management
- ☐ Paying Bills
- ☐ Psychological/Emotional Support
- ☐ Shopping
- ☐ Toileting
- ☐ Transportation
- ☐ Using a post office
- ☐ Using telephones and directories
- ☐ Wound Care
- ☐ Other (please explain) _____

4 Family Member's Absence From Work Details:

Based on your patient's medical necessity, please indicate the most appropriate absence pattern for their care provider. The patient's medical history and your knowledge of the condition should be used to provide an estimated absence need. If end date is unknown, provide the next office visit for reevaluation. Forms marked "Unknown" or "As Needed" will be returned as incomplete. Based on your patient's medical necessity, please indicate the most appropriate absence pattern for their care provider. The patient's medical history and your knowledge of the condition should be used to provide an estimated absence need. If end date is unknown, provide the next office visit for reevaluation. Forms marked "Unknown" or "As Needed" will be returned as incomplete.

☐ **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: When answering these questions, keep in mind that your patient's need for care by the employee seeking leave may include assistance with basic medical, hygienic, nutritional, safety or transportation needs, or the provision of physical or psychological care: 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

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4 Family Member's Absence From Work Details: (cont'd)

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.

5 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.

Date Signed (MM DD YYYY)

X _____

Treating Health Care Provider

* 6 9 1 6 1 D 0 5 *