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 | 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 give permission to my health care provider to clarify information regarding my serious health condition 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.

Date Signed (MM DD YYYY)

X _____

Employee Signature (Explain relationship if other than patient.)

2 Instructions to the HEALTH CARE PROVIDER

All medical facts must be provided by the health care 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 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"** will be returned as insufficient.

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)

Are there any other health care providers involved in your patient's care or has your patient been referred to any other health care provider(s) for evaluation and/or treatment? ☐ Yes ☐ No

Provider First Name | Provider Last Name

Provider 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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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)

☐ **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 consecutive, full calendar days, and any subsequent treatment or period of incapacity related to the same condition (Check all that apply)**

Incapacity of More than 3 days and:

☐ 2 visits to a health care provider within 30 days of the first day of incapacity; or

☐ 1 visit to a Health Care Provider and a regimen of treatment (e.g., 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 at least 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**
- Restorative Surgery after an accident or injury, or
- 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)*

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

Is your patient unable to perform one or more of the essential functions of their job? ☐ Yes ☐ No

If so, identify the job functions the employee is unable to perform:

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3 Absence From Work Details

Please list only dates/times your patient is unable to perform the essential functions of their job due to their serious health 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 insufficient.

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)

☐ **Follow-up Treatment**

Will the employee need to attend follow-up treatment appointments or work part-time or on a reduced schedule because of their medical condition? ☐ Yes ☐ No

If yes, are the treatments or the reduced number of hours of work medically necessary? ☐ Yes ☐ No

Estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

Estimate the part-time or reduced work schedule the employee needs, if any:

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

Hour(s) per day _____ Day(s) per week _____

☐ **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)

Will the condition cause episodic flare-ups periodically preventing the patient from participating in normal activity to work ☐ 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 over the next 6 months (e.g., 1 episode every 1 month lasting 1-2 days):

FREQUENCY: ____ # Times per ○ week, or ○ month, or ○ year **(CHECK ONLY 1)**
(How often/How many times - MUST BE A NUMBER)

DURATION: ____ ○ Hours or ○ Full Days Per Episode
(How long/length of time - MUST BE A NUMBER)

Example:

FREQUENCY: 1 # Times per ○ week, or ☒ month, or ○ year **(CHECK ONLY 1)**
(How often/How many times - MUST BE A NUMBER)

DURATION: 1-2 ○ Hours or ☒ Full Days Per Episode
(How long/length of time - MUST BE A NUMBER)

REMINDER: Include necessary time for travel. Forms marked as"Lifetime," "Unknown," or "As Needed" will be returned as insufficient.

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4 HEALTH CARE PROVIDER

Provider First Name | Provider Last Name

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

Note: The information below 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 disclaimers and notices and also certify that all of the above statements on this form are true.

X _____ Date Signed (MM DD YYYY)

Treating Health Care Provider

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