Prudential

Group Disability Insurance

The Prudential Insurance Company of America
Disability Management Services
P.O. Box 13480, Philadelphia, PA 19176
Phone: (800) 842-1718 Fax: (877) 889-4885
www.prudential.com/forphysicians

Employer Review Capability Form

To Be Completed by the Employee's Health Care Provider at each Office Visit

1

First Name	MI	Last Name	Claim Number

2 To be Completed by Health Care Provider **Work Capacity**†

☐ Employee may return to work with NO restrictions or limitations on: _____ / _______ / _________ (MM/DD/YYYY)

☐ Employee may return to work on: _____ / _______ / _________ (MM/DD/YYYY) with the below restrictions & limitations

☐ Full-time (w/o hourly restrictions) or ☐ Part time with hourly restrictions of _____ hours/day for _____ weeks

☐ Employee has permanent restrictions & limitations listed below as of: _____ / _______ / _________ (MM/DD/YYYY)

PLEASE DO NOT DISCLOSE THE PATIENT'S MEDICAL CONDITION WHEN COMPLETING THIS FORM

Physical or Behavioral Health Restrictions Needed (must be directly related to disabling condition and detailed, *e.g., 25 lb weight limit, walking limited to 2hrs/day, no ladders, may work 4hrs/day x2 weeks w/o restrictions, then full duty, hybrid or work from home with ramp up, verbal only vs. written instructions, quiet space).*

____
____
____
____
____
____

Restrictions Needed Through Date: _____ / _______ / _________ (MM/DD/YYYY)

Estimated Full Duty Release Date: _____ / _______ / _________ (MM/DD/YYYY)

Next Physician Office Visit Date: _____ / _______ / _________ (MM/DD/YYYY)

†Expired restrictions and limitations equate to a full duty release as of the end date. Restrictions and Limitations shall not be based on Human Resources or Employee Relation related issues.

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3 Health Care Provider Information

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 warning and I certify the above statements are true.

Health Care provider Printed Name	Health Care provider Signature	Date (MM/DD/YYYY) _____ / _______ / _________
Address		
Telephone	Fax Number	

Please FAX the completed form within 24 hours after each office visit to (877) 889-4885. Please make sure the claimant's name and claim number are entered at the top of each page. Blank forms are available at: www.prudential.com/forphysicians

FYI - Employees/patients can text a photo of this completed release form from a mobile device via Prudential two-way texting.

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