



Request for NY Paid Family Leave (PFL) Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Based on Form PFL-4)

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/mybenefits

Instructions Included with this Form

TO BE COMPLETED BY THE EMPLOYEE		Control Number	Prudential Claim Number
Employee's name (first name, middle initial, last name)		<input type="text"/>	<input type="text"/>
Employee's Phone Number <input type="text"/>	Employer's Name <input type="text"/>	Employee's Social Security number (or TIN) <input type="text"/>	
Employee's mailing address <input type="text"/>		Employee's date of birth <input type="text"/> / <input type="text"/> / <input type="text"/> (MM/DD/YYYY)	
Mailing address <input type="text"/>			
City, state, zip code, country (if not U.S.A.) <input type="text"/>			

Care recipient's (patient's) name (first name, middle initial, last name)	Care recipient's (patient's) date of birth <input type="text"/> / <input type="text"/> / <input type="text"/> (MM/DD/YYYY)
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The family member is employee's:	Partner	Child	Parent	Other
	Marital Spouse Domestic Partner Civil Union Partner Other	Biological Adopted Foster Stepchild Other	Parent Parent-in-law In-loco Parentis Other	Grandparent Grandchild Child of Domestic Partner Legal Ward Other

If you checked an "Other" relationship, please explain: _____

HEALTH CARE PROVIDER CERTIFICATION FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION (to be completed by the health care provider for the care recipient (patient) and returned to the above-named employee)

Patient Information/family member with serious health condition

(to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

- Does patient require care by the employee requesting Paid Family Leave (PFL)?** ☐ Yes ☐ No (If no, skip to "Health Care Provider Information.") For the purposes of this section, "providing care" may include necessary physical care, emotional support, visitation, assistance in treatment, transportation, arranging for a change in care, assistance with essential daily living matters, and personal attendant services.
- Primary ICD-10 code** (Optional and recommended)
- 3. Diagnosis** _____
- 4. Date patient's condition commenced** / / (MM/DD/YYYY)
- 5. First date care for patient is needed** / / (MM/DD/YYYY)
- 6. Expected date patient will no longer require care** / / (MM/DD/YYYY)
Is the employee's need for leave to provide care Continuous or Intermittent?
☐ Intermittent ☐ Continuous
- 7. If the need to provide care is intermittent, estimated number of days per week OR days per month patient requires care**
_____ Days/week OR _____ Days/month

Health Care Provider Information

- 8. Health care provider's name**

- 10. Health care provider's mailing address**
Mailing address

City, state, zip code, country (if not U.S.A.)

- 9. Type of health care provider:**
☐ Medical Doctor (MD)
☐ Doctor of Osteopathy (DO)
☐ Doctor of Podiatric Medicine (DPM)
☐ Doctor of Chiropractic Medicine (DC)
☐ Dentist (DDS/DDM)
☐ Physician's Assistant (PA)
☐ Nurse Practitioner (NP)
☐ Licensed Psychologist
☐ Licensed Social Worker (LMSW/LCSW)
☐ Other (specify) _____





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TO BE COMPLETED BY THE EMPLOYEE

Employee's name

(first name, middle initial, last name)

Other last names, if any, under which employee has worked

Control Number Prudential Claim Number

Employee's Social Security number (or TIN)

- -

Employee's date of birth

/ / (MM/DD/YYYY)

Care recipient's (patient's) name

(first name, middle initial, last name)

Care recipient's (patient's) date of birth

/ / (MM/DD/YYYY)

HEALTH CARE PROVIDER CERTIFICATION FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION
(to be completed by the health care provider and returned to the above-named employee)

Health Care Provider Information, continued

11. Health care provider's telephone number
(provide area or country code)

12. Health care provider's fax number
(provide area or country code)

13. Health care provider's email address (optional)

**14. State or country (if not U.S.A.) in which
health care provider is licensed to practice**

15. Specialty

16. Health care provider's license number

Certification and signature

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

My signature attests that the information I have provided in this form is based on my professional assessment within my licensed scope of practice.

Health care provider's signature

/ /

Date signed (MM/DD/YYYY)

The employee requesting PFL to care for a family member with a serious health condition must submit the Health Care Provider Certification For Care Of Family Member With Serious Health Condition (GL.2017.188 or Form PFL-4) with the Request For Paid Family Leave (GL.2017.178 or NY Form PFL-1).

- Employee enters their name, date of birth, other last names, if any, under which they have worked, Social Security or Taxpayer Identification Number (TIN) number, mailing address, and care recipient's (patient's) name and date of birth at the top of page 1.
- Employee enters their name and date of birth, and care recipient's (patient's) name and date of birth at the top of page 2.
- Employee gives the Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form GL.2017.188 or PFL-4) to the health care provider.
- When employee receives the completed Health Care Provider Certification For Care Of Family Member With Serious Health Condition (GL.2017.188 or Form PFL-4) form from the health care provider, send the completed forms and supporting documentation to the insurance carrier.





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HEALTH CARE PROVIDER CERTIFICATION FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION (to be completed by the health care provider for the care recipient (patient) and returned to the above-named employee)

The patient's health care provider must complete all applicable requested information unless noted as optional.

Question 2: Providing the optional ICD-10 code is recommended.

Patient Information/family member with serious health condition

(to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

The patient's health care provider must complete the Patient Information and Health Care Provider sections of the *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (GL.2017.188 or Form PFL-4)*.

Health Care Provider signs and dates, and then returns the form to the employee requesting PFL.

Note to the healthcare provider:

Content of medical certification taken because of the serious health condition of a family member.

a. Required information. When leave is taken because of the serious health condition of a family member, the employee must obtain a medical certification from a health care provider that sets forth the following information:

1. Name, address, telephone number, email address (if available), license number and state of license of the health care provider, and the type of medical practice/specialization;
2. Approximate date on which the serious health condition commenced, and its probable duration;
3. Certification regarding the patient's health condition for which PFL is requested. The certification must be sufficient to support the need for leave; and
4. An estimate of the frequency and duration of the leave required to care for the family member, including whether the need for care is continuing or on an intermittent basis.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 USC 552a).

The Workers' Compensation Board's (Board's) authority to request that employees provide personal information, including their social security number or tax identification number, is derived from the Board's administrative authority under Workers' Compensation Law section 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate records. Providing your social security number or tax identification number to the Board is voluntary. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.





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Paid Family Leave Definitions

"Serious health condition" means an illness, injury, impairment, or physical or mental condition that involves: inpatient care in a hospital, hospice, or residential health care facility; or continuing treatment or continuing supervision by a health care provider.

- i. As used in this subchapter, "continuing treatment or continuing supervision by a health care provider" means one or more of the following:
- a. A period of more than three consecutive, full days during which a family member is unable to work, attend school, perform regular daily activities, or is otherwise incapacitated due to illness, injury, impairment, or physical or mental conditions, and any subsequent treatment or period of incapacity relating to the same condition, that also involves:
 1. Treatment two or more times by a health care provider; or
 2. Treatment on at least one occasion by a health care provider, which results in a regimen of continuing treatment under the supervision of the health care provider.
 - b. Any period during which a family member is unable to work, attend school, perform regular daily activities, or is otherwise incapacitated due to a chronic serious health condition. A chronic serious health condition is one which:
 1. Requires periodic visits for treatment by a health care provider;
 2. Continues over an extended period of time (including recurring episodes of a single underlying condition); and
 3. May cause episodic rather than a continuing period of incapacity. Examples of such episodic incapacity include but are not limited to asthma, diabetes, and epilepsy.
 - c. A long-term or permanent period during which a family member is unable to work, attend school, perform regular daily activities, or is otherwise incapacitated due to an illness, injury, impairment, or physical or mental condition for which treatment may not be effective. The family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include, but are not limited to, Alzheimer's, a severe stroke, or the terminal stages of a disease.
 - d. A period during which a family member is unable to work, attend school, perform regular daily activities, or is otherwise incapacitated because he or she is receiving treatment (including any period of recovery therefrom) by a health care provider for:
 1. Restorative surgery after an accident or other injury; or
 2. A condition that would likely result in a period of incapacity of more than three consecutive full days in the absence of medical intervention or treatment. Examples include, but are not limited to, cancer (e.g., chemotherapy and radiation), severe arthritis (physical therapy), or kidney disease (dialysis).
- ii. As used in this subchapter, the term treatment includes (but is not limited to) examinations to determine if a serious health condition exists and evaluations of the condition. Treatment does not include routine examinations. Examples of a regimen of continuing treatment includes, but is not limited to, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition (e.g., oxygen). A regimen of continuing treatment that includes the taking of over-the-counter medications (e.g., aspirin, antihistamines, or salves), bed rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider, is not, by itself, sufficient to constitute a regimen of continuing treatment for purposes of leave under this subchapter.
- iii. Conditions for which cosmetic treatments are administered (such as most treatments for acne or plastic surgery) are not serious health conditions unless inpatient hospital care is required or unless complications develop. Ordinarily, unless complications arise, the common cold, the flu, earaches, upset stomach, minor ulcers, headaches other than migraine, routine dental or orthodontia problems, periodontal disease, etc., are examples of conditions that do not meet the definition of a serious health condition and do not qualify for leave under this subchapter. Restorative dental or plastic surgery after an injury or removal of cancerous growths are serious health conditions provided all the other conditions of this paragraph are met. Mental illness or allergies may be serious health conditions, but only if all the conditions of this paragraph are met.

If you believe the care recipient is the victim of abuse or neglect caused by the employee requesting PFL, you may decline to provide this certification.

