aetna℠

Attending Physician Statement

Complete and sign the form using BLUE or BLACK ink.

Aetna Life Insurance Company
PO Box 14560
Lexington, KY 40512-4560

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 of the individual, 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 individuals' 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. ***Please note that it is appropriate under GINA to provide family medical history when an employee is requesting leave to care for a family member.***

1. Patient Instructions – The Physician will complete Sections 2 through 7.
The Patient will complete Sections 1 and 8.
The Patient should also fill in their name at the top of Pages 2 and 3.

The ***Patient*** is responsible for completing this section and for **ensuring** that **their Attending Physician completes the remainder of this statement**. The Patient is responsible for paying any fees that may be charged for completion of this form by their physician. **If you have any questions, please call (866) 326-1380.**

(a) Control Number _____

(b) _____ / _____ / _____ / _____
Patient Name (Last, First, Middle Initial) | Social Security Number | Year of Birth | Height | Weight (lbs)

(c) Patient Gender ☐ Male ☐ Female

(d) _____
Patient Home Address – Required (Current No., Street, Town, State, ZIP – no PO boxes) ☐ Check if New

(e) Mailing Address, if different from Home Address _____

(f) Patient Employer Name/City/State _____

(g) Patient Telephone Number _____ ☐ **Check if New**

(h) Job Title/Occupation _____

(i) Type of Claim: ☐ Short Term Disability ☐ Long Term Disability ☐ Waiver of Premium
☐ Long Term / Permanent Total Disability

2. Physician Instructions

The ***Attending Physician*** should **complete the items below,** based upon a **recent examination.** Attach additional documentation as needed. If you have any questions, please call (**866) 326-1380.**

Please complete form in its entirety and fax to (866) 667-1987. Pages 2 and 3 MUST be completed before faxing.

3. Impairing Diagnosis & Treatment

(a) **For medical reasons, the patient will need to be absent from work due to a disability beginning on** _____ **and ending on** _____ **.**
(MM/DD/YYYY) (MM/DD/YYYY)

(b) Primary Diagnosis _____ Primary ICD Code _____
Secondary Diagnosis _____ Secondary ICD Code _____
Other Diagnoses _____ Other ICD Codes _____

(c) Height _____ Weight _____ Date Measured (MM/DD/YYYY) _____

(d) If Pregnancy related, delivery or expected due date Month _____ Day _____ Year _____
Delivery Type: ☐ Vaginal ☐ Cesarean

(e) Surgery Date ..... Month _____ Day _____ Year _____
Primary Procedure _____ Primary CPT Code _____
Secondary Procedure _____ Secondary CPT Code _____
Other Procedures _____ Other CPT Codes _____

(f) Medication(s)/Dose/Frequency _____

_____

Impairment from medication effects _____

(g) Is patient still under your care for this condition? ☐ Yes ☐ No Date service terminated _____
(MM/DD/YYYY)

(h) Treatment Summary _____

(i) Office Visit Dates: First _____ Last _____ Next _____ Frequency of appointments _____
(MM/DD/YYYY) (MM/DD/YYYY) (MM/DD/YYYY)

(j) Was patient recently hospitalized? ☐ No ☐ Yes Date hospitalized: Admit _____ Discharge _____
(MM/DD/YYYY) (MM/DD/YYYY)

(k) Hospital Name/City/State _____

Patient Name *(Last, First, Middle Initial)* **Required**

4. History

(a) Symptoms: _____

_____

(b) Date symptoms first appeared or accident happened Month _____ Day _____ Year _____

(c) Has patient ever had same or similar condition? ☐ No ☐ Yes State when and describe.

_____

(e) Is condition due to injury or sickness arising out of patient's employment? ☐ No ☐ Yes ☐ Unknown

(f) Other Treating Physicians

Name _____ Specialty _____ City _____ State _____

Name _____ Specialty _____ City _____ State _____

5. Abilities/Limitations

(a) **Patient is: Place remarks in item (d) below, if applicable.**

- Competent to endorse checks and direct the use of proceeds thereof .... ☐ Yes ☐ No ☐ Other/describe in (d)
- Able to work with others ..... ☐ Yes ☐ No ☐ Other/describe in (d)
- Able to give supervision ..... ☐ Yes ☐ No ☐ Other/describe in (d)
- Able to work cooperatively with others in group setting ..... ☐ Yes ☐ No ☐ Other/describe in (d)
- Able to do? **Select one: Place remarks in item (d) below, if applicable.**
  - ☐ **Heavy work** activity. No limitations of functional capacity.
  - ☐ **Medium work** activity. Exerting 20-50 pounds of force occasionally, and/or 10-25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly.
  - ☐ **Light work** activity. Exerting up to 20 pounds of force occasionally and/or up to 10 pounds of force frequently.
  - ☐ **Sedentary work** activity. Moderate limitation of functional capacity. Exerting up to 10 pounds of force occasionally. (Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time.)
  - ☐ **No ability to work.** Severe limitation of functional capacity; incapable of minimal activity.
  - ☐ **Other.** Place remarks in item (d) below.

(b) **What medical restrictions/limitations are you placing on patient?** ***(Activities of Daily Living, Driving, Lifting, Pulling, Pushing, and Amounts, etc.)*** _____

_____

_____

- Number of Hours patient is capable of working in a day: ☐ 12 ☐ 10 ☐ 8 ☐ 6 ☐ 4 ☐ 2 ☐ 1 Hour/Day
- Number of Days per week patient is able to work: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 Days/Week
- Date you prescribed restriction on work activities: Month _____ Day _____ Year _____
- How long are these restrictions/limitations in effect? _____ Days _____ Weeks _____ Months ☐ No Longer
- Estimated return to work date? _____ (MM/DD/YYYY) Modified Duty _____ (MM/DD/YYYY) Full Duty

(c) **Objective findings that substantiate impairment** *(current laboratory, physical and/or mental status examination and other testing)*

_____

(d) Other/Comments _____

_____

6. Current Status

(a) Patient has ☐ Improved ☐ Stabilized ☐ Regressed ☐ Not Applicable

(b) Is there a medical contraindication for patient to participate in Vocational Rehabilitation (job training) programs?

☐ No ☐ Yes, please explain _____

(c) In your opinion, is your patient motivated to return to work? _____

7. Physician Information

Attending Physician's Name ***(Print)***	Degree	Specialty
Address *(No. Street, City, State, ZIP Code)*	Telephone Number	Fax Number
Signature		**Date** *(MM/DD/YYYY)*

Patient Name *(Last, First, Middle Initial)* **Required**

8. Regulation Notice

Any person who knowingly and with intent to injure, defraud or deceive 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 subjects such person to criminal and civil penalties.

Attention Alabama Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

Attention Arkansas, District of Columbia, Rhode Island and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention California Residents: For your protection, California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Florida Residents: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Attention Kansas and Missouri Residents: Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Attention Louisiana Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application is guilty of a crime and may be subject to fines and confinement in prison.

Attention Maine and Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Attention Maryland Residents: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy or knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Attention New York Residents: 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 be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Attention North Carolina Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and subjects such person to criminal and civil penalties.

Attention Ohio Residents: Any person who, with intent to defraud or knowing he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Attention Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Attention Oregon Residents: Any person who with intent to injure, defraud or deceive any insurance company or other person submits an enrollment form for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto may have violated state law.

Attention Pennsylvania Residents: 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 subjects such person to criminal and civil penalties.

Attention Puerto Rico Residents: Any person who knowingly and with the intention to defraud includes false information in an application for insurance or file, assist or abet in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars ($5,000), not to exceed ten thousand dollars ($10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

Attention Vermont Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 may be a crime and may subject such person to criminal and civil penalties.

Attention Virginia Residents: Any person who knowingly and with intent to injure, defraud or deceive 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 act, which is a crime and subjects such person to criminal and civil penalties.

Attention Washington Residents: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.