ATTENDING PHYSICIAN'S DISABILITY STATEMENT

TO BE COMPLETED (for employee) BY PHYSICIAN

Legible completion of this form is requested to ensure prompt service to your patient.

1. Patient Name/Medical Record Number (please print, maiden name if applicable)
2. Date of Birth Height Weight
3. When did symptoms first appear or accident happen?
4. Date you advised patient to stop working?
5. Has patient ever had the same or similar condition? ☐ Yes ☐ No If yes, state when and describe
6. Is condition due to or exacerbated by injury/ sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown
7. Name & address of other treating physicians
8. Date of first visit for this illness
9. Date of last visit
10. Diagnosis & ICD10 code (include complications)
11. Subjective symptoms
12. Objective findings (including current x-rays, EKG's lab and/or clinical findings)
13. Nature of treatment
14. If pregnancy, expected delivery date
15. If delivered, actual delivery date
16. ☐ Vaginal delivery ☐ C - Section
17. Was patient hospitalized? ☐ Yes ☐ No — Name & address of hospital — Date Admitted — Date Discharged
18. Please check patients Physical Capacity (Reference: Dictionary of Occupational Titles)
    - ☐ Very heavy – frequent standing/walking, lift/carry over 100 lbs.
    - ☐ Heavy - frequent standing/walking, lift/carry up to 100 lbs.
    - ☐ Medium - frequent standing/walking, lift/carry up to 50 lbs.
    - ☐ Light - frequent standing/walking, lift/carry up to 20 lbs
    - ☐ Sedentary – sitting most of the time, lift/carry up to 10 lbs.
    - ☐ No work capacity – ADLs (Activities of Daily Living) only.
19. Behavioral Health (Reference: DSM-IV-TR)
    - ☐ GAF 61-70 – Some mild symptoms (some difficulty in social, occupational); generally functioning well.
    - ☐ GAF 51-60 – Moderate symptoms (moderate difficulty in social, occupational); flat affect, occasional panic attacks, conflict with peers.
    - ☐ GAF 41-50 Serious symptoms (serious impairment in social, occupational); no friends, suicidal, unable to keep job.
    - ☐ GAF 31-40 Some impairment in reality testing, speech at times illogical, major impairment in several areas.
    - ☐ GAF < 30 Behavior influenced by delusions and/or hallucinations; acts grossly inappropriate.
20. Please define "stress" as it applies to this patient
21. What stress and problems in interpersonal relations has patient had on the job?
22. Additional Remarks
23. Please describe any *limitations your patient has in his/her activities (*limitations – activities that cannot be performed).
24. Please list any *restrictions you have placed on your patient's activities (*restrictions – activities that should not be done to prevent progression of disease).
25. Expected Return to Work Date
26. Can patient resume full duties upon return to work? ☐Yes ☐ No If no, please explain?
27. Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? ☐Yes ☐ No

Signature of Attending Physician

The above statements are true and complete to the best of my knowledge and belief.
I acknowledge that I have completed this form in its entirety.

Physician's Name	Degree & Specialty	NPI Number
Street Address	Phone Number	Fax Number
Are you related to this patient? Y N	If yes, what is the relationship?	
Physician's Signature (eSignature is allowed)		Date Signed

Please fax, email or mail this statement to UnitedHealthcare Specialty Benefits, at the following locations:

Fax: 888 505 8550 **Unsecured E-mail:** FPCustomerSupport@uhc.com **Mail:** PO Box 7466 Portland ME 04112-7466

(Rev. 01/18)

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

For claimants in Alabama:
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.

For claimants in Alaska:
A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

For claimants in Arizona:
For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

For your protection California law requires 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.

For claimants in Colorado:
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.

For claimants in Connecticut:
Any person who knowingly presents false information in an application for insurance or life settlement contract is guilty of a crime and may be subject to fines and confinement in prison.

For claimants in Delaware:
Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

For claimants in District of Columbia:
WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For claimants in Florida:
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

For claimants in Hawaii:
For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

For claimants in Idaho:
Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

For claimants in Indiana:
A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete, or misleading information commits a felony.

For claimants in Kansas:
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 may be guilty of fraud as determined by a court of law.

For claimants in Kentucky:
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.

FRAUD WARNING NOTICES: (Please review notice that applies in your state)

For claimants in Maine:
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 a denial of insurance benefits.

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

For claimants in Minnesota:
A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

For claimants in New Hampshire:
Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

For

UnitedHealthcare Specialty Benefits

PO Box 7466 Portland ME 04112-7466
Tel 888 299 2070
Fax 888-505-8550

Claims Department
Direct Deposit Agreement
For Payment of Benefit to Financial Institution

Section 1 (to be completed by benefit recipient)

Name of Benefit Recipient

UHCSB Disability Claim Number

UHCSB Policy Number

Social Security Number

Telephone Number

Address (Number, Street, Route, P.O. Box, APO/FP, including directional such as NE, NW, SE, SW etc)

City

State

Zip (preferably the nine digit ZIP code)

"I authorize UnitedHealthcare Specialty Benefits to direct the net amount of my benefit payment to be deposited directly by electronic funds transfer and credited to my account as indicated at the financial institution designated below. If any payments made are dated after the date of my death, I hereby authorize and direct the said financial institution on my behalf and on behalf of my executors or administrators to refund any such payments to UnitedHealthcare Specialty Benefits and to charge the same to my account."

PLEASE ATTACH A VOIDED BLANK CHECK TO THIS FORM

Signature of Benefit Recipient (eSignature is allowed)

Date Signed

Section 2

Name of Financial Institution

Address ((Number, Street, Route, P.O. Box, APO/FP, including directional such as NE, NW, SE, SW etc)

City

State

Zip (preferably the nine digit ZIP code)

Routing Number (9 digit number in lower left corner of check)

Bank Account Number (numbers following the Routing Number)

Type of Account ☐ Checking ☐ Savings (check one)