ATTENDING PHYSICIAN STATEMENT

Claim #

MetLife

Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 40511-4590
Fax: 1-800-230-9531

Instructions for completing the claim form:

1 Complete all applicable areas of the claim form.
2 Sign the claim form. Fax: 1-800-230-9531
3 Fax this claim form to expedite your claim – retain original for your records.

The following section must be completed and signed by the employee/patient.
Any fee for the completion of this form is the patient's responsibility

Occupation

Name-**MUST ANSWER**	Social Security#	Employer-**MUST ANSWER**	Group Report #

I hereby authorize my physician to release any information acquired in the course of examination or treatment

Signature of Employee _____ Date _____

Date of Birth

The following section must be completed and signed by the attending physician.
The purpose of this report is to assist us in making a disability determination. Please complete all applicable sections of this form.
A MetLife claim representative may telephone your office if additional information is needed.

History

Symptoms result from: ☐ Injury ☐ Illness

Is condition work related? ☐ Yes ☐ No

Initial date of treatment _____

Most recent date of treatment _____

Did you advise the patient to cease the above noted occupation? ☐ Yes ☐ No If Yes, Date _____

Names and Phone Numbers of the providers the patient was referred to:

Name _____ Phone # _____ Name _____ Phone # _____

Has patient been hospitalized? ☐ Yes ☐ No If Yes, Day Confined _____ Through _____

Name and address of facility:

_____

Diagnosis and Treatment

Primary ICD-9 _____ Diagnosis _____

Secondary ICD-9 _____ Diagnosis _____

Subjective Symptoms _____

_____

Objective Findings (include copies/results of any x-rays, lab tests, EKG's, MRI's, scans and office notes)

_____

Current and Recommended Treatment Plans _____

_____

_____

If surgery performed/anticipated, provide the following:

CPT-4 _____ Procedure _____ Date _____

Medications prescribed (names, dosages)

_____ _____

_____ _____

Name of Employee: _____ Social Security Number: _____

Psychological Functions

Check applicable box below

- ☐ Class 1 – Patient is able to function under stress and engage in interpersonal relations (no limitations)
- ☐ Class 2 – Patient is able to function in most stress situations and engage in some interpersonal relations (slight limitations)
- ☐ Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
- ☐ Class 4 – Patient is unable to engage in stress situations and engage in interpersonal relations(marked limitations)
- ☐ Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)

Remarks: _____

What stress factors or problems with interpersonal skills have affected patient's ability to perform, the duties of his or her job? _____

Is patient competent to endorse checks and direct use of the proceeds? ☐ Yes ☐ No

Physical Capabilities

(a) Patient's ability to: (check)

	Hours		
Sit	0 1 2 3 4 5 6 7 ☐	Continuously ☐	Intermittently ☐
Stand	0 1 2 3 4 5 6 7 ☐	Continuously ☐	Intermittently ☐
Walk	0 1 2 3 4 5 6 7 ☐	Continuously ☐	Intermittently ☐

(b) Patient's ability to: (circle)

Climb	Yes	No
Twist/bend/stoop	Yes	No
Reach above shoulder level	Yes	No
Operate a motor vehicle	Yes	No

(c) Patient's ability to lift/carry: (check)

	Never 0%	Occasionally 1-35%	Frequently 36-66%	Continuously 67-100%
Up to 10lbs	☐	☐	☐	☐
11 to 20 lbs	☐	☐	☐	☐
21 to 50 lbs	☐	☐	☐	☐
51 to 100lbs	☐	☐	☐	☐
Over 100 lbs	☐	☐	☐	☐

(d) Patient's ability to perform repetitively: (circle)

	Right Hand		Left Hand	
Fine Finger movements	Yes	No	Yes	No
Eye/hand movements	Yes	No	Yes	No
Pushing/pulling	Yes	No	Yes	No
Dominant Hand	Right		Left	

(e) In your opinion, is patient totally disabled from performing any job, including but not limited to his/her current job? _____

(f) Patient can work a total of _____ hours per day?

(g) Do you expect improvement in any area? (If so please comment and give dates/timeframes.) ☐ Yes ☐ No _____

Cardiac

Functional Capacity (American Heart Association) Complete only if applicable.

☐ Class 1 (No Limitation) ☐ Class 2 (Slight Limitation) ☐ Class 3 (Marked Limitation) ☐ Class 4 (Complete Limitation)

Blood Pressure (latest reading) _____ as of (date) _____

Is patient in a cardiac rehabilitation program? ☐ Yes ☐ No

Prognosis

If patient can work with medical restrictions please specify those restrictions on work and on activity.

Have you advised patient to return to work?

☐ Yes If Yes, date of return _____ ☐ To regular occupation ☐ Full Time ☐ Part Time

☐ To any other occupation ☐ Full Time ☐ Part Time

☐ No If Not, please explain _____

Any work/activity restrictions applicable (please be specific) _____

Name of Employee: _____ Social Security Number: _____

Rehab

Do you suggest that the patient become involved in any of the following? Please check as many as apply.
If so, was this discussed with the patient? ☐ Yes ☐ No

- ☐ Physical Therapy
- ☐ Job Modification
- ☐ Work Hardening Program
- ☐ Pain Management Program
- ☐ Other
- ☐ Cardiac Rehabilitation
- ☐ Occupational Therapy
- ☐ Psychological Counseling
- ☐ Vocational Rehabilitation

Fraud Warning:

New York: [only applies to Accident and Health Benefits (AD&D/Disability/Dental)]: I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important. I know that if I do this, I may also have to pay a civil penalty of up to $5,000 plus the value of the claim.

Florida: 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 of the third degree.

Massachusetts: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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, and may subject such person to criminal and civil penalties.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Oklahoma: 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.

Kansas and Oregon: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud, and may be subject to criminal and civil penalties.

Puerto Rico: Any person who, knowingly and with intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented, a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more then ten (10,000), or imprisonment for a fixed term of three (3) year, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5)

Virginia: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, files a claim containing a false or deceptive statement may have violated state law.

California: 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.

If you reside in any state other than those listed above, then the following warning may apply to you:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 and subjects such person to criminal and civil penalties.

Physician

Name _____ Degree/Specialty _____
Address _____ City _____ State _____ Zip Code _____
Phone# _____ Fax# _____
Contact Person _____

Signature _____ Date _____