Madison National Life

Insurance Company, Inc.
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ATTENDING PHYSICIAN'S STATEMENT

THIS IS A TIME SENSITIVE DOCUMENT

Thorough completion of this form will provide the information necessary to allow us to work closely with your patient and his/her employer to develop a plan which will promote a return to work. This form must be completed by a physician.

Name of patient:_____ Date of birth:_____

Address:_____
Street City State Zip

A. DIAGNOSIS / HISTORY

Primary diagnosis:_____ ICD-9 code:_____
Secondary diagnosis:_____ ICD-9 code:_____
Other diagnoses and ICD codes related to this claim:_____

DSM IV Axis I – V (GAF):_____
Symptoms:_____

Is the condition primarily related to: ☐ Employment ☐ Illness ☐ Mental Disorder ☐ Alcohol or Drug Dependence ☐ MVA ☐ Pregnancy ☐ Injury

Date patient became unable to work due to this impairment? Month_____ Day_____ Year_____

Date your patient can return to work: Part time:_____ Full time:_____
OR unable to determine, due to:_____ Follow up in: _____

Patient's Height: _____ Patient's Weight: _____ BP:_____ Patient's Dominant Hand: ☐ Right ☐ Left
Date symptoms first appeared:_____ Date of first visit to you for this condition:_____
Date of most recent visit:_____ Date of next visit:_____
Has your patient ever had the same or similar condition? ☐ No ☐ Yes If yes, indicate when and describe:_____

B. TREATMENT PLAN

Planned course of treatment (please include expected duration, surgeries, therapy, etc.):_____

Treatment complicated by: ☐ Employer / Employee conflict ☐ Significant emotional or behavioral disorder
☐ Alcohol or Drug Dependence ☐ MVA ☐ Other _____

Medications prescribed (dosage, frequency and date of prescriptions (please feel free to use a separate sheet of paper):_____

Frequency with which you see your patient: ☐ Weekly ☐ Monthly ☐ PRN ☐ Other:_____
Has your patient been referred to other doctors or therapy programs (P.T., O.T., psychotherapy)? ☐ No ☐ Yes If yes please indicate to whom and dates:

If your patient is not working now, does the treatment plan include a definitive strategy for his/her return to work? For example, have you had contact with the patient's employer regarding possible job modifications or gradual return to work? ☐ No ☐ Yes If yes please describe the return to work plan:_____

C. HOSPITALIZATION: (If not hospitalized please proceed to next section.)

If patient was hospitalized, please provide dates: Admitted_____ Discharged_____
Admitting diagnosis:_____ ICD-9 code:_____
Discharge diagnosis:_____ ICD-9 code:_____
Name of hospital:_____ Name of doctor seen at hospital:_____
Address:_____
Street City State Zip Code

D. SURGERY: (If surgery was not performed or is not anticipated to be necessary in the future please proceed to next section.)

Was surgery performed? ☐ No ☐ Yes If yes indicate procedure and date of surgery: _____

Is surgery planned? ☐ No ☐ Yes If yes indicate planned procedure and anticipated date:_____

Name of Patient:_____ Date of Birth_____

E. PREGNANCY: (If patient is not pregnant please proceed to next section.)

If disability is related to pregnancy, please provide the following: LMP_____ First obstetric visit:_____
Expected date of delivery_____ Actual date of delivery_____ Type: ☐ C-Section ☐ Vaginal
Have there been complications resulting in disability prior to delivery? ☐ No ☐ Yes If yes indicate the type of complication:_____

F. ASSESSMENT

Describe your patient's condition since onset of symptoms: ☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed
Has your patient reached maximum medical improvement? ☐ No ☐ Yes
If your patient has not reached maximum medical improvement, when do you expect a fundamental or marked change in his/her condition?
☐ Never ☐ Condition expected to regress ☐ Condition expected to improve, State anticipated date_____ ☐ Unable to determine
Is confinement to bed or home medically required? ☐ No ☐ Yes. If yes, please indicate duration of confinement. _____

G. RESTRICTIONS AND LIMITATIONS

If physical or psychiatric limitations exist, how long do you feel that these limitations will last?_____
Has your patient provided a self-report of his/her job tasks? ☐ No ☐ Yes
Based on your knowledge of your patient's job, what reasonable work or job site modifications could the employer make to assist him/her to return to work?

Level of functional impairment:

In a work day, given two breaks and a meal break, your patient can:
Lift (in pounds) ☐ 1 – 10 ☐ 11 – 20 ☐ 21 – 50 ☐ 51 – 75 ☐ 76+
Carry (in pounds) ☐ 1 – 10 ☐ 11 – 20 ☐ 21 – 50 ☐ 51 – 75 ☐ 76+
Bend/Stoop: ☐ Never ☐ Occasionally ☐ Frequently (how frequently)_____

If allowed positional changes, patient can: (please circle one for each)
Sit: 8 7 6 5 4 3 2 1 0 (hrs)
Stand: 8 7 6 5 4 3 2 1 0 (hrs)
Walk: 8 7 6 5 4 3 2 1 0 (hrs)
Alternately sit/stand : 8 7 6 5 4 3 2 1 0 (hrs)

If the total number of days that the patient can work during a week is limited, please specify the number of days the claimant can work per week. _____

Patient can work with arms in the following positions:
Right arm: Above shoulder ☐ No ☐ Yes Below shoulder ☐ No ☐ Yes
Left arm: Above shoulder ☐ No ☐ Yes Below shoulder ☐ No ☐ Yes

Patient can use arms/hands for repetitive action such as:
Right arm: Gross movements ☐ No ☐ Yes Pushing& pulling ☐ No ☐ Yes Fine movements ☐ No ☐ Yes
Left arm: Gross movements ☐ No ☐ Yes Pushing& pulling ☐ No ☐ Yes Fine movements ☐ No ☐ Yes

Patient can use his/her head and neck in:
Flexion ☐ Not at all ☐ Occasionally ☐ Frequently ☐ Continuously
Extension ☐ Not at all ☐ Occasionally ☐ Frequently ☐ Continuously
Rotation ☐ Not at all ☐ Occasionally ☐ Frequently ☐ Continuously

Mental Impairment (if applicable)

Please define "stress" as it applies to this claimant: _____
What stress and problems in interpersonal relations has this claimant had on the job? _____

☐ 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 most 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 or engage in interpersonal relations. (Marked limitations.)
☐ Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment. (Severe limitations.)

Remarks: _____
What obstacles prevent a return to work?_____
If no, would you like assistance in developing a return to work plan? ☐ No ☐ Yes
Would you recommend vocational rehabilitation services (assignment of a case manager to assist your patient and the employer in return to work planning, or to provide assistance in finding a new job, or in designing a retaining plan which would allow a return to work)? ☐ No ☐ Yes
Comments:_____

PLEASE READ CAREFULLY*************************************

MEDICAL RECORDS ARE REQUIRED IN ORDER FOR A PROPER REVIEW OF THIS CLAIM. WE ASK THAT YOU ATTACH COPIES OF LABORATORY DATA, RESULTS OF DIAGNOSTIC TESTS, OFFICE VISIT NOTES, PATIENT SURGICAL REPORTS, HOSPITALIZATION RECORDS, CHART NOTES AND NARRATIVE REPORTS FROM THREE MONTHS BEFORE DISABILITY THROUGH PRESENT DATE. LACK OF MEDICAL RECORDS WILL RESULT IN A DELAY IN THE REVIEW OF THIS CLAIM AND A DELAY IN POSSIBLE PAYMENT OF BENEFITS.

I have received and read the fraud warning statements provided with this form.

Physician's signature:_____ **Date:**_____

Physicians name (please print):_____ Specialty:_____

Address:_____ City_____ State:_____ Zip code:_____

Phone number:_____ **Medical record department fax number:**_____

Fraud Warnings

WARNING: 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 may be guilty of a crime and subject to fines, confinement in prison and/or denial of insurance benefits. This warning applies to the following states: Alabama, Alaska, Arkansas, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming.

ARIZONA WARNING: 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.

CALIFORNIA WARNING: 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.

COLORADO WARNING: 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 damage. 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.

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.

FLORIDA WARNING: 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.

KENTUCKY WARNING: 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.

NEW HAMPSHIRE WARNING: 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.

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

NEW YORK WARNING: 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 $5,000 and the stated value of the claim for each such violation.

OREGON WARNING: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer by submitting an application, or by filing a claim containing a false statement as to any material fact, may be violating state law.

PENNSYLVANIA WARNING: 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.

WASHINGTON WARNING: 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.

Signature: _____ Date: _____