



# Attending Physician Statement

Complete and sign the form using BLUE or BLACK ink.

Aetna Life Insurance Company  
P.O. Box 14554  
Lexington, KY 40512-4554

- 1. Patient Instructions** – The Physician will complete Sections 2 through 7.  
 The Patient will complete Section 1.  
 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 1-888-554-0887.**

(a) Control Number 698456, Aetna Inc.

(b) \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
 Patient Name (Last, First, Middle Initial) Social Security Number Birth Date (MM/DD/YYYY) Height Weight(lb)

(c) Patient Gender  Male  Female

(d) \_\_\_\_\_  
 Patient Home Address – Required (Current No., St., 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 **1-888-554-0887**.

**Please complete form in its entirety and fax to (866) 888-2308. 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 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? \_\_\_\_\_  No Longer  
 Days Weeks Months
- Estimated return to work date? \_\_\_\_\_ modified duty \_\_\_\_\_ full duty  
 (MM/DD/YYYY) (MM/DD/YYYY)

(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 Arkansas, Louisiana 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, Ohio and 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 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 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 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 may subject such person to criminal and civil penalties.

**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 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 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 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.

Employee's Signature

Date (MM/DD/YYYY)