Guardian

STD Ongoing Physician's Statement of Disability

Send to: Group STD Claims, P.O. Box 14331, Lexington, KY 40512 **Customer Service: (800) 268-2525, fax: (610) 807-8270**
Documents can be returned electronically at www.GuardianAnytime.com. Click on "Secure Channel" on the Guardian Anytime home page.

EMPLOYEE SECTION

1. Employee Name	2. DOB ____ / ____ / ____	3. Plan #	4. Claim #

5. Address	City	State	Zip	6. Phone # ( )

7. Employer Name	8. Occupation

AUTHORIZATION

I authorize any physician, medical practitioner, hospital, clinic, other health facility, consumer reporting agency, the Social Security Administration, the Medical Information Bureau, insurance or reinsurance company, or employer to release any and all medical and non-medical information in its possession about me to The Guardian Life Insurance Company of America or its legal representatives. Medical information means all information in the possession of or derived from providers of health care regarding the medical history, mental or physical condition, or treatment of me. I understand that Guardian will use the information obtained by this authorization to determine eligibility for insurance or eligibility for benefits under an existing plan. Guardian will not release any information obtained to any person or organization except to reinsurance companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim, or as may be lawfully required or permitted, or as I may further authorize. I know that I may request and receive a copy of this authorization. I have the right to cancel this authorization in writing at any time. I agree that a photocopy of this authorization shall be as valid as the original. I agree that this authorization shall be valid up to 24 months (12 months in Kansas) from the date shown below.

"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. In New York the person shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. In California, any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties."

Signature _____ Date ____ / ____ / ____

PHYSICIAN SECTION

Completion of this form will help to expedite processing of the claim and reduce additional requests and follow up. Your patient is responsible for the cost of completing this form.

1. Current Diagnosis (including any complications)	ICD9 or DSM IV Codes:
2. Subjective Symptoms	

CURRENT TREATMENT

3. Describe this patient's treatment program: (including any surgeries with date and CPT codes) _____

_____

Current Medication Profile: _____

Therapy Type: _____ Frequency: _____

Counseling Type: _____ Frequency: _____

4. Frequency of visit/treatment for this condition	5. Date of your first evaluation for this condition	6. Date of next visit/treatment
☐ Weekly ☐ Monthly ☐ Other _____	____ / ____ / ____	____ / ____ / ____

7. Please supply complete name, address and specialty of any other treating physicians or hospitals including phone # and fax #.

Name	Specialty	Address	Phone #	Fax #	Treatment From	Treatment To
					___ / ___ / ___	___ / ___ / ___
					___ / ___ / ___	___ / ___ / ___
					___ / ___ / ___	___ / ___ / ___

If additional space is needed, please attach a separate sheet

ASSESSMENT

8. Has patient reached maximum medical improvement? ☐ Yes ☐ No Date for MMI ____ / ____ / ____

9. Patient condition is ☐ Recovered ☐ Not Changed ☐ Improved ☐ Retrogressed

10. Has patient been released to return to work? ☐ Yes ☐ No

If "Yes", date patient was released to return to work? ☐ Part Time ____ / ____ / ____ ☐ Usual Occupation ☐ Full Time ____ / ____ / ____ ☐ Usual Occupation with another employer ☐ Other Occupation

11. If not yet released to return to work, when do you anticipate a release? ____ / ____ / ____ ☐ Part Time ☐ Full Time ☐ Never

12. Is patient a candidate for vocational rehabilitation? ☐ Yes ☐ No

LEVEL OF FUNCTIONAL IMPAIRMENT

13. In a work day given two breaks and a meal break, your patient can:

Lift/carry (in pounds) ☐ 1-10 ☐ 11-20 ☐ 21-50 ☐ 51-75 ☐ 76+

Push/pull (in pounds) ☐ 1-10 ☐ 11-20 ☐ 21-50 ☐ 51-75 ☐ 76+

	Total	With positional change
Sit	8 7 6 5 4 3 2 1 (hrs)	_____
Stand	8 7 6 5 4 3 2 1 (hrs)	_____
Walk	8 7 6 5 4 3 2 1 (hrs)	_____
Alternately sit/stand	8 7 6 5 4 3 2 1 (hrs)	_____

Bend/stoop: ☐ Never ☐ Occasionally ☐ Frequently

Reach: ☐ Never ☐ Occasionally ☐ Frequently

Drive: ☐ Never ☐ Occasionally ☐ Frequently

Dominant Hand: ☐ Right ☐ Left

14. Other Restrictions: _____

_____

15. Duration of Restrictions: _____

16. Degree of mental/nervous impairment

Axis 1 _____

Axis 2 _____

Current GAF (Global Assessment of Functioning) _____/90

Axis 3 _____

Axis 4 _____

17. Describe patient's mental and cognitive limitations, if any _____

_____

18. Do you believe that this patient is competent to endorse checks and direct the use of the proceeds? ☐ Yes ☐ No

19. **Degree of Cardiac Functional Capacity** (American Heart Association)

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

Please supply patient's: height _____ weight _____ blood pressure _____

PLEASE ATTACH PERTINENT MEDICAL RECORDS INCLUDING BUT NOT LIMITED TO PROGRESS NOTES, DIAGNOSTIC TEST RESULTS, DISCHARGE SUMMARIES, OPERATIVE REPORTS, CONSULTATION REPORTS AND MENTAL STATUS EXAM (IF APPLICABLE). THIS WILL HELP TO EXPEDITE PROCESSING OF CLAIM AND REDUCE ADDITIONAL REQUESTS AND FOLLOW UP. YOUR PATIENT IS RESPONSIBLE FOR THE COST OF THE MEDICAL RECORDS.

PHYSICIAN INFORMATION

20. Physician's Name	21. Degree	22. Specialty	
23. Address	24. City	25. State	26. Zip
27. Telephone # ( )	28. Fax # ( )	29. Tax ID #	

30. **Remarks**

FRAUD NOTICE

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. This includes Employee and Attending Physician portions of the form.

✖_____ Date ____ / ____ / _____

Signature of Physician (no stamp)

Fraud Warning Statements

The laws of several states require the following statements to appear on the claim form:

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.

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.

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.

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.

Connecticut, Iowa, Kansas, Nebraska, Oregon, and Vermont: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or 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 a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

Delaware, Indiana and Oklahoma: WARNING: Any person who knowingly, and with the 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.

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: 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: 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.

Louisiana and Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment or a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties or denial of insurance benefits.

Maine, Tennessee, Virginia and Washington: 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 benefit.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or 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.

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

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 N.H. Rev. Stat. Ann. § 638:20.

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

Ohio: Any person who with intent to defraud or knowing that he/she 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.

Pennsylvania: 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.

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or 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.