Indicate type of claim
☐ A&S/STD/Salary Continuance ☐ LTD

Disability Claim
Attending Physician Statement

MetLife®
Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 40511-4590
Fax: 1-866-690-1264

Instructions for completing the claim form:
1. **Complete all applicable areas of the claim form.**
2. **Sign the claim form.**
3. **Fax this 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 # - **MUST ANSWER**	Employer - **MUST ANSWER**	Group Report #
I hereby authorize my physician to release any information acquired in the course of my 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 ☐ Pregnancy If pregnancy, delivery date _____ ☐ Expected _____ ☐ Actual

Is condition work-related? ☐ Yes ☐ No Type of delivery _____

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 other providers the patient was referred to:

Name	Phone #	Name	Phone #

Has patient been hospitalized? ☐ Yes ☐ No If Yes, Date 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)

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Continued on Reverse Side

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 or 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: (circle)

	Hours	(check)	
Sit	0 1 2 3 4 5 6 7 8	☐ Continuously	☐ Intermittently
Stand	0 1 2 3 4 5 6 7 8	☐ Continuously	☐ Intermittently
Walk	0 1 2 3 4 5 6 7 8	☐ 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 10 lbs.	☐	☐	☐	☐
11 to 20 lbs.	☐	☐	☐	☐
21 to 50 lbs.	☐	☐	☐	☐
51 to 100 lbs.	☐	☐	☐	☐
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	R_____		L_____	

(e) In your opinion, why is patient unable to perform job duties?

(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.)

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?

Prognosis

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):

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

Disability Claim Attending Physician Statement (Continued)

Name of Employee: _____ Social Security Number: ___-___-____

Fraud Warning:

If you reside in one of the following states, one of the following state warnings may apply to you:

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.

Kansas and Massachusetts: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

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.

Virginia: Any person who, with the 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.

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 _____

Street Address _____ City _____ State _____ Zip Code _____

Telephone # (___) _____ Fax # (___) _____ Tax ID # _____

Contact person if additional information is necessary _____

Signature _____ Date _____

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