Prudential

Group Disability Insurance

The Prudential Insurance Company of America
Disability Management Services
PO Box 13480, Philadelphia, PA 19176
Tel: 877-367-7781 Fax: 877-889-4885
www.prudential.com/forphysicians

Certification of Health Care Provider for Employee's Serious Health Condition for Disability and Family Medical Leave Act

1

First Name | MI | Last Name | Claim Number

Social Security Number | Date of Birth (MM DD YYYY) | Gender ☐ Female ☐ Male

Employer's Name | Control Number (required)

For disability purposes, have this certification completed by a doctor as defined in the group contract.

By the signature below, I give permission to my provider to clarify information regarding the clinical reason for me to take time from work as described within this document. I understand that the required information, if not provided by the due date, may result in my leave not being approved or other action by my employer.

X _____
Employee Signature (Explain relationship if other than patient.) | Date Signed (MM DD YYYY)

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For disability purposes, this certification must be completed by a doctor as defined in the group contract. All medical facts must be provided by the treating provider. Documentation must be provided in English or be accompanied by a translation of medical facts. Please attach written statements to this form if more space is needed. Your signature is required on the last page of this form.

Your patient has requested leave under the FMLA and his/her company's disability program. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency and length of a condition, treatments, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "Lifetime," "Unknown," or "As Needed" will not be sufficient to determine FMLA or disability payment coverage. Without sufficient medical fact, this form will be returned as incomplete.

Which of the following best describe your patient's medical condition?

☐ Injury — Motor Vehicle Accident (MVA) ☐ Yes ☐ No — If MVA, in what state did it occur?

☐ Illness

☐ Pregnancy ☐ Estimated Delivery Date ☐ Actual Delivery Date (MM DD YYYY)

Date when significant loss of function occurred (MM DD YYYY)

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ Yes ☐ No

If yes, provide name and address of hospital:

Date Admitted (MM DD YYYY)

Date Discharged (MM DD YYYY)

Dates you treated the patient for this condition: First Visit (MM DD YYYY) | Last Visit (MM DD YYYY) | Next Visit (MM DD YYYY)

Are there any other treating providers or consultants involved in your patient's care? ☐ Yes ☐ No

Other Treating Providers or Consultants:
If there is more than one Other Treating Provider or Consultant, please use an additional page to provide their information.

First Name | Last Name

Specialty | Telephone Number

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Failure to complete this section will not impact your patient's rights under the FMLA. All information provided will be taken into consideration for the disability benefit and FMLA purposes.

Clinical Diagnosis **ICD Code is Required**

Primary:

Secondary:

Secondary:

If patient had surgery, please provide the date and procedure details on the line below.

Date of Surgical Procedure (MM DD YYYY)

Do you feel the claimant is competent to endorse checks and direct the use of proceeds? ☐ Yes ☐ No

In the space provided below, please describe relevant medical facts, if any, related to the condition for which the employee seeks leave from work (i.e., diagnosis, pregnancy complications, symptoms, or any regimen of continuing treatment such as the use of specialized equipment)

Relevant tests and surgical procedure(s) other than listed above – Provide specific details, including dates of all procedures

Current medications, treatment, and prognosis

Nature of medical impairment (i.e., loss of function)

Are there any non-medical factors which have a significant impact on functional abilities (i.e., interpersonal, financial, family)?

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4 **Return To Work Details**

Return To Work Date (MM DD YYYY) Full Time ☐ Part Time ☐ Work Limitations (functions lost) ☐

Were you provided with a job description for your patient, or did you discuss the essential functions of their job? ☐ Yes ☐ No

During their absence, what job function(s) is/was your patient unable to perform due to this medical condition?

Describe the return to work plan, and provide any corresponding limitations.

Absence From Work Details.
Please list only dates/times, it is medically necessary for the patient to be absent from work due to this medical condition. The patient's medical history and your knowledge of the condition should be used to provide an estimated absence need. If the end date is unknown, provide the next office visit for reevaluation.
Forms marked as "Lifetime," "Unknown," or "As Needed" will be returned as incomplete.

Which of the following best describes the absence pattern? (check all that apply)

☐ Single Continuous Absence ☐ Short-term Episodic Absences ☐ Chronic or Lifelong Absences (Minimum of 2 office visits per year required)

Please describe the expected absence from work needed:

☐ Single Continuous Absence Period Start Date (MM DD YYYY) End Date (MM DD YYYY)

☐ Foreseeable (i.e., appointments, therapy) ☐ Unforeseeable (i.e., Flare-Ups) ☐ Both Foreseeable and Unforeseeable

INTERMITTENT ABSENCE DETAILS: Provide an estimate of the frequency and the length of related incapacity or scheduled appointments that the patient may have.

Example

FREQUENCY: ____ Times per ○ week, or ○ month, or ○ year **(check only 1)**
LENGTH ____ minute(s), ____ hour(s) or _____full day(s) per episode

FREQUENCY: **_3__**Times per ○ week, or ☒ month, or ○ year **(check only 1)**
LENGTH: ____ minute(s), **_2_** hour(s) or _____full day(s) per episode

REMINDER: Include necessary time for travel. "Lifetime," "Unknown," or "As Needed," or the like will be returned as incomplete information.
For approximately how long will your patient need the intermittent "time away from work" outlined above? An estimate must be provided.

Start Date (MM DD YYYY) End Date (MM DD YYYY)

REMINDER: Forms marked as "Lifetime," "Unknown," or "As Needed" will be returned as incomplete

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First Name | MI | Last Name | Claim Number

Provider First Name | Provider Last Name

Provider Area of Specialty (i.e., General Practitioner, Oncologist, Obstetrician)

Office Phone Number | Office Fax Number

Office Address | Suite

City | State | ZIP Code

Please Read

GINA Disclaimer: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information," as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Fraud Notice: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

I have read and understand the terms and requirements of the fraud notice and disclaimer. I certify the above statements are true.

I understand for disability purposes, this certification must be completed by a doctor as defined in the group contract.

X _____ Date Signed (MM DD YYYY)

Treating Provider