

# ATTENDING PHYSICIAN'S STATEMENT

This form is to be completed  
without expense to Liberty Mutual and returned  
along with your original claim for benefits or  
by the date requested by the Liberty Mutual Claims Dept.



Group Market Disability Claims  
Liberty Life Assurance  
Company of Boston  
P.O. Box 7211  
London, KY 40742-7211  
Phone No.: 888-440-6118  
Fax No.: 603-422-0117

Return to: \_\_\_\_\_

EMPLOYEE/CLAIMANT NAME: _____	
CLAIM NO.: _____	S.S. NO.: _____ - _____ - _____
EMPLOYER/SPONSOR: _____	DATE OF BIRTH: _____

## AUTHORIZATION TO OBTAIN AND RELEASE INFORMATION

I authorize any licensed physician, medical provider, hospital, medical facility, HMO, pharmacy, government agency, including the Social Security Administration and Veterans Administration, insurance or reinsurance company, credit or consumer reporting agency, financial/educational institutions and any current or former employer to release any and all medical information with respect to my physical or mental condition and/or treatment of me, including confidential information regarding AIDS/HIV infection, communicable diseases, alcohol and substance abuse, mental health and any non-medical information to the particular Company in the Liberty Mutual Group of companies to which I am submitting a claim, or to its legal representative, or to the Plan Sponsor (if Self Insured Plan), or to persons or other organizations providing claims management services.

I understand the Company or Plan Sponsor will use the information obtained under this Authorization or directly from me to determine eligibility for insurance benefits, which may include assessing ongoing treatment. Any information obtained will not be released to any person or organizations EXCEPT to the Plan Sponsor, reinsuring companies, other companies in the Liberty Mutual Group of companies to which I am submitting a claim, Employee Assistance Programs (EAP) or other disease management or assistance programs providing services to the Plan Sponsor and/or to the Company, persons or other organizations providing claims management and claim advisory services to the Plan Sponsor and/or to the Company, the Group Policyholder or its agents/vendors for purposes of auditing the Company's administration of claims under the policy and/or assessing statistical claim data related to its benefit programs, and persons or organizations providing medical treatment or services in connection with my claim, or as may be otherwise permitted or required by law.

If I receive a disability benefit greater than that which I should have been paid, I understand that the Company has the right to recover such overpayment from me, including the right to reduce future disability benefits, if any.

I understand that any person who knowingly, and with intent to injure, defraud, or deceive the Company and/or Plan Sponsor, files a statement or claim containing any false, incomplete, or misleading information may be guilty of a criminal act punishable under law.

I know that I may request a copy of this Authorization. I agree that a photographic copy of this Authorization shall be as valid as the original. This Authorization shall become effective on the date appearing next to my signature below. I understand that this Authorization shall be valid for two years from the date appearing below with my signature and that I have the right to revoke this Authorization at any time by written notification to the Company in the Liberty Mutual group of companies to which I submit a claim and/or the Plan Sponsor.

Date

Claimant's Signature (or Authorized Representative)

## PHYSICIAN'S INSTRUCTIONS

**PLEASE NOTE: IF ANY PORTION OF THIS FORM IS NOT COMPLETED, WE WILL BE REQUIRED TO REQUEST THE INFORMATION WHICH WILL RESULT IN A DELAY IN DETERMINATION OF YOUR PATIENT'S DISABILITY BENEFITS.**

**THE CLINICAL INFORMATION, IN COMBINATION WITH THE PHYSICAL FACTORS OF YOUR PATIENT'S JOB AND THE CONTRACTUAL PROVISIONS UNDER WHICH HE/SHE IS COVERED, WILL BE USED TO ESTABLISH THE MOST APPROPRIATE WORK ABSENCE DURATION.**

<b>1. DIAGNOSIS</b>		
Primary _____	ICD9 _____	
Secondary _____	ICD9 _____	
_____	ICD9 _____	
Has patient ever had the same or a similar condition?    Yes _____    No _____		
If "Yes", state when and describe. _____		
What is your prognosis? _____		
For Pregnancy:		
EDC _____	Date of Delivery _____	Type _____
<b>2. DATES OF TREATMENT</b>		
(a) Date of First Visit _____		(mo/day/yr)
(b) Date of Last Visit _____		(mo/day/yr)
(c) Frequency of Visits _____	Weekly _____ Monthly _____	Other (specify) _____
(d) Date of First Treatment _____		(mo/day/yr)
(e) Date Symptoms First Appeared / Accident Occurred _____		(mo/day/yr)
(f) Date Patient Advised to Cease Work _____		
(g) Estimated Return to Work Date _____		

PHYSICIAN, PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM.

PART A: TO BE COMPLETED BY EMPLOYEE

PART B: TO BE COMPLETED BY ATTENDING PHYSICIAN

3. Please describe in detail your PROPOSED TREATMENT PLAN. Please list all medications the patient is taking for this condition. Include your prognosis as a result of this treatment plan. IDENTIFY ANY RESTRICTIONS you have imposed on your patient at this time.

4. PHYSICAL IMPAIRMENT

- Class 1 - No limitation of functional capacity; capable of heavy work.
- Class 2 - Medium manual activity.
- Class 3 - Slight limitation of functional capacity; capable of light work.
- Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative activity.
- Class 5 - Severe limitation of functional capacity; incapable of minimum activity.

REMARKS:

5. MENTAL/NERVOUS IMPAIRMENT

- 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 stressful situations and engage in most interpersonal relations (slight limitations).
- Class 3 - Patient is able to engage in only limited stressful situations and engage only in limited interpersonal relations (moderate limitations).
- Class 4 - Patient is unable to engage in stressful situations or engage in interpersonal relations (marked limitations).
- Class 5 - Patient has significant loss of psychological, physiological, personal, and social adjustment (severe limitations).

REMARKS:

6. CARDIAC IMPAIRMENT (if applicable)

Functional Capacity:  Class 1: No Limitation  Class 2: Slight Limitation  
 (per American Heart Assn)  Class 3: Marked Limitation  Class 4: Complete Limitation

Blood Pressure (last visit): \_\_\_\_\_  
(systolic/diastolic)

7. Date of Next Scheduled Visit

Are you still treating the patient?  Yes  No  
 If patient has been referred to another physician, please indicate the name of physician, address, telephone number, and reason for referral.

Was patient referred to you by another physician?  Yes  No

8. Has patient been hospital confined?  Yes  No

Dates of Confinement: From \_\_\_\_\_ to \_\_\_\_\_  
 Was surgery performed?  Yes  No If "Yes", please indicate procedure(s) performed:  
 CPT Code: \_\_\_\_\_ Date Performed \_\_\_\_\_  
 Name and Address of Hospital: \_\_\_\_\_

9. After you have completed this form, please attach copies of the following materials:

- Office notes for the period of treatment or for the last two years
- Test Results showing medical evidence
- Hospital discharge summary (if applicable)
- Consulting physician's reports (if applicable)

10. REMARKS

Attending Physician's Name (PLEASE PRINT) _____	Degree/Specialty _____	SS No. or Tax ID No. _____
Street Address _____	( ) _____ Telephone No.	( ) _____ Fax No.
City/State/Zip Code _____	Signature _____	Date _____