Health Care Provider Certification

This box is for Aetna use only
Date Received By Leave Coordinator:
Leave Coordinator's Name:
Claim Number:
Employer's Name:

If you have any questions please call us at 1-800-552-5506. Please fax to **1-866-667-1987** or return to:

Aetna Disability and Leave Management
P.O. Box 14560
Lexington, KY 40512-4560

It is the EMPLOYEE'S RESPONSIBILITY to ensure that all documentation is completed fully and returned to Aetna within 15 calendar days.

Employee Name	Employee Signature	
Patient Name	Relationship	Date of Birth

Healthcare Provider ONLY
(Please complete the following questions as related to the **PATIENT'S** condition. **Sections A**, **B**, and **C MUST** always be completed.)

A. 1. Describe the medical facts that support your certification, including a brief statement explaining how the medical facts meet the criteria of **ONE** of the serious health conditions in **Question B**.

_____

2. Provide a description of any regimen of continuing treatment for the patient under your supervision. (e.g., prescribed drugs, therapy, appointments).

_____

3. How often is the patient treated for this condition (e.g., appointments, prescribed drugs)?
x/week _____, or x/month _____, or x/yr _____

B. If the health condition qualifies as a "**Serious Health Condition**", please check the applicable category, and proceed to **Section 3**.

☐ **1) Hospital Care -** Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of *incapacity* or subsequent treatment in connection with such inpatient care.

☐ **2) Absence Plus Treatment -** A period of incapacity of **more than three consecutive calendar days** (including any subsequent treatment or period of incapacity relating to the same condition), that also involves:
- *Treatment*[2] two or more times by a healthcare provider, nurse or physician's assistant under direct supervision of a healthcare provider, or by a provider of healthcare services (e.g., physical therapist) under order, or on referral by a healthcare provider; or
- Treatment by a healthcare provider on at least one occasion resulting in a regimen of *continuing treatment*[3] under the supervision of a healthcare provider.

☐ **3) Pregnancy -** Any period of incapacity due to pregnancy, or for prenatal care. Please proceed to **Section C**.
What is the expected/actual delivery date? _____ **Are there complications?** ☐ **Yes** ☐ **No**

☐ **4) Chronic Condition Requiring Treatments** - A chronic condition which:
- Requires periodic visits for treatment by a healthcare provider, or by a nurse or physician's assistant under direct supervision of a healthcare provider;
- Conditions over an extended period of time (including recurring episodes of a single underlying condition); and
- May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.).

☐ **5) Permanent/Long Term Conditions Requiring Supervision** - A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The Employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a healthcare provider.

☐ **6) Multiple Treatments (No Chronic Condition)** - Any period of absence to receive multiple treatments (including any period of recovery) by a healthcare provider or by a provider of healthcare services under orders of, or on referral by, a healthcare provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of **more than three consecutive days** in the absence of medical intervention or treatment, such as cancer, chemotherapy, radiation, severe arthritis (physical therapy), or kidney disease (dialysis).

Name

Healthcare Provider ONLY *(Continued)*

C. Please complete the following based on the patient's needs. If the patient is not the Employee, please also complete **Section D**.

- Approximate date the condition began or was diagnosed: _____ Most recent date of treatment: _____
- What Is the leave need for (Please select all that apply and complete the following questions in this section.)?

☐ **CONTINUOUS ABSENCE:**
- What is/was the first date of this continuous absence? _____
  Date patient is able to return to normal activities: _____

☐ **INTERMITTENT ABSENCE:**
- How long will the patient be affected by this condition (e.g., date of full duty release, lifelong, etc.)? _____
- How often is the patient incapacitated due to this condition:
  no capacity at all _____, or x/week _____, or x/month _____, or x/yr _____
- Indicate probable duration of each episode of incapacity: _____ hours or _____ days

☐ **REDUCED HOURS:**
- How long will the patient be affected by this condition (e.g., date of full duty release, lifelong, etc.)? _____
- What is the schedule (hours able to work per day)?
  M _____ Tu _____ W _____ Th _____ F _____ Sa _____ Su _____

D. 1. ☐ Yes ☐ No If leave is required to **care for a family member** of the Employee with a serious health condition, **does the patient require assistance** for basic medical or personal needs or safety, or for transportation?
x/week _____, or x/month _____, or x/yr _____

2. ☐ Yes ☐ No If leave is required to **care for an adult child (son or daughter[4])** of the Employee with a serious health condition, **does the patient require assistance** with three or more activities of daily living (ADLs) or instrumental activities of daily living (IADLs) under the ADA (e.g., personal grooming and hygiene, dressing, and eating; others are cooking, cleaning, etc.)?

3. ☐ Yes ☐ No If No, would the Employee's presence to provide **psychological comfort** be beneficial to the patient or assist the patient's recovery?

4. If the patient will need care only **intermittently,** please indicate the probable **duration** of this need: ___ week(s); ___ month(s); _____ No capacity at all.

Signature of Healthcare Provider		Print Name of Healthcare Provider	
Date Form Completed	Type of Practice	Telephone Number	Fax Number
Address			

To be completed by the employee needing family leave to care for a family member.

State the care that you will provide and an estimate of the period during which care will be provided, including a schedule if leave is to be taken intermittently or if it will be necessary for you to work less that a full schedule.

_____ _____
Signature of Employee Date

1. ***"Incapacity"1***, for purposes of FMLA, is defined to mean inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment thereof, or recovery there from.
2. "***Treatment"2*** includes examinations to determine if a serious health condition exists and evaluations of the condition. Treatment **does not include** routine physical examinations, eye examinations, or dental examinations.
3. ***A regimen of "continuing treatment"3*** includes, for example, a course of prescription medication (e.g., an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves, or bed-rest, drinking fluids, exercise and or other similar activities that can be initiated without a visit to a healthcare provider.
4. "***Son or daughter***" means a biological, adopted, or foster child, a stepchild, a legal ward, or a child of a person standing in loco parentis.

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