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 Family Member's Serious Health Condition (Family and Medical Leave Act)

1 Employee/Caregiver Information

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)

By the signature below, I attest that the information in this document is intended to support my need to be absent from work in order to provide care for my family member as outlined by the treating physician.

Date Signed (MM DD YYYY)

X _____
Employee Signature

2 Patient/Family Member Information

Patient First Name | MI | Last Name

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

Relationship to employee: Please check ONLY one.

Partner	**Child**	**Parent**	**Other**
☐ Marital Spouse*	☐ Minor (Under age 18)	☐ Parent	☐ Describe relationship on the line provided below.
☐ Domestic Partner	☐ Adult – NOT Disabled	☐ Parent-in-Law	
☐ Civil Union Partner	☐ Adult – With Disability**	☐ Other: (Describe relevant facts.)	
☐ Other: (Describe relevent facts.)	☐ Other: (Describe relevant facts.)		

* "Spouse" means a person to whom you are lawfully married.

****Disabled Adult Child/ADA Qualified:** Individual age 18 or older and incapable of self care because of a mental or physical disability that substantially limits 3 or more ADLs or IADLs.

3 Instructions for the HEALTH CARE PROVIDER

All medical facts must be provided by the treating physician. 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.

The employee listed above has requested leave under the FMLA to care for your patient. Answer, fully and completely, all applicable parts below. Several questions seek a response as to the frequency or length of a condition or treatment. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Limit your responses to the condition for which the employee is seeking absence from work. Be as specific as you can; terms such as **"Lifetime," "Unknown," or "As Needed"** may not be sufficient to determine FMLA coverage. Without sufficient medical fact, this form will be returned as incomplete.

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

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

Continued on Page 2.

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First Name	MI	Last Name	Claim Number

3 Instructions for the HEALTH CARE PROVIDER (cont'd)

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., pregnancy complications, or any regimen of continuing treatment such as the use of specialized equipment).

What is the approximate date the condition commenced? (MM DD YYYY)

What is the expected duration the condition will last? (MM DD YYYY)

Will the patient need treatment visits at least twice per year due to this condition? ☐ Yes ☐ No

Was medication prescribed that may not be obtained over the counter? ☐ Yes ☐ No

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

Dates of admission: 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)

In the space provided below, please describe the care needed by the patient and why such care is medically necessary. If care is for an adult child, list ADLs or IADLs your patient requires support to perform (i.e., cooking, toileting, travel to appointments).

In the space provided below, please list any past or future absence dates due to treatments, recovery, flare-ups, and travel time due to this medical condition. Provide any additional relevant information specific to the need for family members to take time away from work to care for your patient.

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

Family Member's Absence From Work Details:
Based on your patient's medical necessity, please indicate the most appropriate absence pattern for their care provider. The patient's medical history and your knowledge of the condition should be used to provide an estimated absence need. If end date is unknown, provide the next office visit for reevaluation. **Forms marked "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

Continued on Page 3.

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First Name | **MI** | **Last Name** | **Claim Number**

3 Instructions for the HEALTH CARE PROVIDER (cont'd)

INTERMITTENT ABSENCE DETAILS: Provide an estimate of the frequency and the length of the family member's time away from work. Include necessary travel time for scheduled appointments that the patient may have.

FREQUENCY: ____Times per ○ week, or ○ month, or ○ year **(Check only 1.)**

LENGTH: ____ minute(s), ____ hour(s) or _____full day(s) per episode

Example:

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: Forms marked as "Lifetime," "Unknown," "As Needed," or the like, will be returned as incomplete information.

For approximately how long will your patient need the intermittent support outlined above? An estimation must be provided.

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

Physician First Name | Physician Last Name

Physician 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 all of the terms and conditions of the above fraud notice and disclaimer and also certify that all of the above statements on this form are true.

X _____ Date Signed (MM DD YYYY)

Treating Health Care Provider

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