Attending Physician Behavioral Health Statement

Complete and sign the form using BLUE or BLACK ink.

Aetna Global Benefits®

Aetna Global Benefits
Attn: Disability Claims Processing
P.O. Box 30258
Tampa, FL 33630-3258
USA
Phone: 800-231-7729
(Outside USA – use AT&T access)
813-775-0190
(Direct or collect outside the USA)
Fax: 800-475-8751 (Toll Free)
813-775-0625 (Direct)

**1. Patient Instructions – The Physician will complete Sections 2 through 9.
The Patient will complete Section 1.
The Patient should also fill in their name at the top of Pages 2 and 3.**

The ***Patient*** is responsible for completing this section, and for **ensuring** that their **Attending Physician completes the remainder of this statement.** The Patient is responsible for paying any fees that may be charged for completion of this form by their physician. **If you have any questions, please call us at the number above.**

(a) Control Number ______________________

(b) Patient Name ______________________
(Last Name/Surname, First, Middle Initial)

______________ U.S. Social Security/ ID #   ______________ Birth Date *(MM/DD/YYYY)*   ________ Height   ________ Weight(lb)

(c) Patient Gender ☐ Male ☐ Female

(d) Patient Home Address ______________________
Required *(Include Country)* ☐ Check if New

(e) Mailing Address, if different from Home address ______________________

(f) Patient Employer Name/Address ______________________
(Include Country)

(g) Patient Telephone Number ______________________ ☐ **Check if New**
(Include Country Code)

(h) Job Title/Occupation ______________________

(i) Type of Claim: ☒ Long Term Disability

2. Physician Instructions

The ***Attending Physician*** should **complete the items below,** based upon a **recent examination.** Attach additional documentation as needed. **If you have any questions, please call us at the number above.**

Please complete form in its entirety and fax to the number above. Pages 2 and 3 MUST be completed before faxing.

3. Impairing Diagnosis & Treatment

DSM IV-TR MULTIAXIAL DIAGNOSIS: (please indicate the primary impairing diagnosis at this time with an*)

AXIS I Primary Diagnosis __________ Secondary Diagnosis: __________ ICD-9 codes __________

AXIS II Primary Diagnosis __________ Secondary Diagnosis: __________ ICD-9 codes __________

AXIS III Primary Diagnosis __________ Secondary Diagnosis: __________ ICD-9 codes __________

Axis IV Primary Diagnosis __________ Secondary Diagnosis: __________

Axis V (GAF) CURRENT ________ High last year __________ Goal for return to work __________

(Please support GAF with objective findings in the symptom assessment section below)

SYMPTOM ASSESSMENT

(a) Subjective symptoms and complaints:

(b) Objective findings(Include mental status findings, testing results, rating scales, etc)

(c) Describe interpersonal stressors that impact ability to function ______________________

(d) Describe work stressors that impact ability to function ______________________

TREATMENT

(a) Medication(s) / Dose / Frequency: ______________________

(b) Impairment from medication effects ______________________
Compliant with meds? ______________________

(c) Was patient recently hospitalized? ☐ No ☐ Yes Date hospitalized: Admit __________ *(MM/DD/YYYY)* Discharge __________ *(MM/DD/YYYY)*

Hospital Name (Include Country) ______________________

(d) Office visit dates: First __________ Last __________ Next __________ Frequency of appointments ________

(e) Compliant with tx? ________ Tx Goals ______________________

Coverage underwritten by Aetna Life Insurance Company and Aetna Life & Casualty (Bermuda) Ltd.

Patient Name *(Last Name/Surname, First, Middle Initial)* **Required**

4. History

(a) Has patient ever had same or similar condition? ☐ No ☐ Yes, state when and describe

____

(b) Is condition due to injury or illness arising out of patient's employment? ☐ No ☐ Yes ☐ Unknown

(c) Name / Specialty / Country/ City / State of other Treating Physicians or Therapists

Name ____________ Specialty ____________ City ____________ State ______ Country ______

Name ____________ Specialty ____________ City ____________ State ______ Country ______

Name ____________ Specialty ____________ City ____________ State ______ Country ______

5. Abilities/Limitations

(a) **Is this person capable of signing checks and directing the proceeds?** ____________

(b) **Please check the appropriate response of the employee's ability to perform these job functions now.**

	Limitations	**Limited**	**Marked**	**Unable To Perform**
Follow work rules	☐	☐	☐	☐
Able to work with others	☐	☐	☐	☐
Able to give supervision to others	☐	☐	☐	☐
Able to work cooperatively with others in group settings	☐	☐	☐	☐
Able to maintain persistence to task	☐	☐	☐	☐
Able to maintain attention and concentration	☐	☐	☐	☐
Able to work alone or in physical isolation from others	☐	☐	☐	☐
Able to interact with supervisors	☐	☐	☐	☐
Able to interact with public/customers	☐	☐	☐	☐
Able to use judgement and make decisions	☐	☐	☐	☐
Able to attain set standards and limits	☐	☐	☐	☐
Able to direct, control or plan activities of others	☐	☐	☐	☐

(c) **Objective findings that substantiate Impairment** *(current laboratory, physical and/or mental status examination, and other testing)*:

____

____

(d) **What psychological/medical restrictions/limitations are you placing on this patient? *(Activities of Daily Living, Driving, etc)***

____

____

- Number of Hours patient is capable of working in a day: ☐ 12 ☐ 10 ☐ 8 ☐ 6 ☐ 4 ☐ 2 ☐ 1 Hour/Day
- Number of Days per week patient is able to work: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 Days/Week
- Date you prescribed restriction on work activities Month __________ Day __________ Year ______
- How long are these restrictions/limitations in effect? ______ Days ______ Weeks ______ Months ☐ No Longer
- Estimated return to work date? __________ *(MM/DD/YYYY)* modified duty __________ *(MM/DD/YYYY)* full duty

(e) Other/ Comments ____

6. Current Status

(a) Patient is/has ☐ Improved ☐ Unchanged ☐ Regressed

(b) Is there a medical contra-indication for patient to participate in Vocational Rehabilitation (job retraining) programs?

☐ No ☐ Yes, please explain ____

(c) In your opinion, is your patient motivated to return to work? ____________________________

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Patient Name *(Last Name/Surname, First, Middle Initial)* **Required**

7. Regulation Notice

Any person who knowingly and with intent to injure, defraud or deceive any insurance company or other person files an application for insurance or 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.

Attention California Residents: For your protection, California law requires notice of the following to appear on this form. Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Attention Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

Attention Florida and Virginia Residents: Any person who knowingly and with intent to defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Attention Kentucky, Ohio and Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 may subject such person to criminal and civil penalties.

Attention Louisiana and West Virginia Residents: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Attention Maine and Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

Attention New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Attention New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

8. Physician Certification

Attending Physician's Name ***(Print)***	Degree	Specialty
Address *(Include Country)*		
Telephone Number (Include Country Code)	Fax Number (Include Country Code)	
Are you a western trained physician? ☐ Yes ☐ No University/Institution *(Include Country)* ________________		

9. Physician Signature

Signature	**Date** *(MM/DD/YYYY)*

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