

DISABILITY REPORT

I. Name _____ DOB: ____ / ____ / ____ Sex: ____
Last First MI Mo Day Yr M/F

LICENSED TREATING PHYSICIAN/EVALUATOR: QUESTIONS MUST BE ANSWERED COMPLETELY and LEGIBLY OR FORM MAY BE RETURNED

II. Describe all significant physical and mental illnesses, accidents, deformities, injuries, illnesses and surgeries related to your patient's disability. Specify date(s) applicable to condition(s) listed and attach copies of all related reports.

III. Current diagnoses (List primary diagnosis first)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

IV. Indicate your treatment plan and duration of treatment:

V. Explain in detail your patient's functional limitation(s) in doing medium and/or light (sedentary) work. Base your decision on medical evidence and not on subjective judgment. Attach copies of all medical evidence to this report.

VI. LICENSED PHYSICIAN'S STATEMENT OF DISABILITY

Your patient's disability is expected to be:

- PERMANENT
- AT LEAST 12 MONTHS, RE-EVALUATION NEEDED: _____ (MO/YR)
- TEMPORARY TO: _____ (MO/YR)

(Print/Type Name of Licensed Treating Physician/Evaluator) (Signature of Licensed Treating Physician/Evaluator)

(Address) (City) (Zip Code) (Phone No.) (Date)

(Name of Health Plan) (Medical Provider No. or NPI)

VII. PATIENT ACKNOWLEDGEMENT

(Print/Type Name of applicant/recipient) (Patient Contact Number)

(Signature of applicant/recipient, Guardian or Representative) (Date)

If Applicant/Recipient or Guardian or Representative do not sign, indicate reason: _____

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FOR OFFICIAL USE ONLY

(Case Name) (Case No.)

(Worker's Name) (Section Unit)

(Unit Address) (Phone No.) (Fax No.)