

SDI Online Tutorial:

Physician/Practitioner and

Physician/Practitioner Representative

Registration, Online Access Information, and

Form Submission

SDI Online Overview for Physicians/Practitioners and Representatives

The way you access Employment Development Department (EDD) benefits and services has changed.

You will now complete a one-time registration for Benefit Programs Online, but will still file your Disability Insurance (DI) and Paid Family Leave (PFL) medical certifications using SDI Online.

Physicians/practitioners and Physician/practitioner representatives:

You may use SDI Online to:

- Complete medical certifications for Disability Insurance and Paid Family Leave benefits.
- Complete medical certifications for benefits on behalf of the physician/practitioners.
- Update contact information.
- Access electronic requests for additional medical information.

- A physician/practitioner may have an unlimited number of authorized representatives.
- A physician/practitioner representative may create an account after the physician/practitioner has added them as an authorized representative to their SDI Online account.
- An individual may be an authorized representative for an unlimited number of physicians/practitioners.

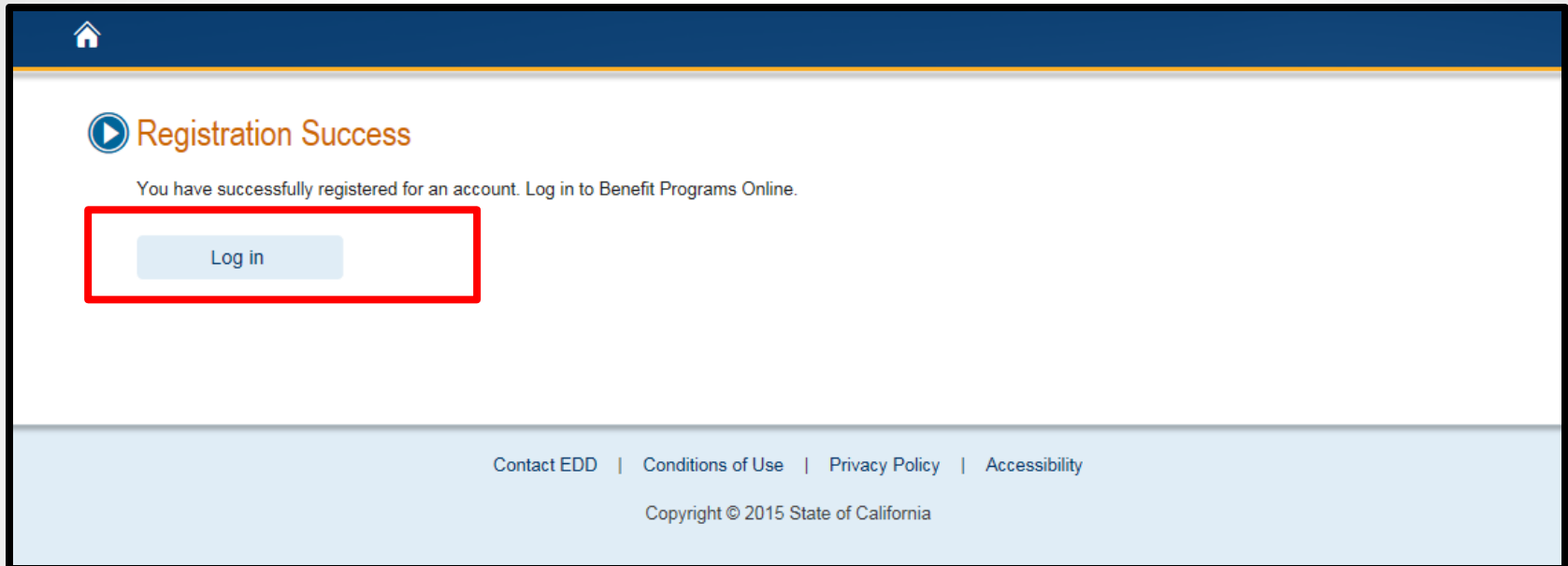
New Registration Benefit Programs Online

You must first complete a one-time registration in Benefit Programs Online to access SDI Online as a physician/practitioner or physician/practitioner representative.

To register for Benefit Programs Online, visit:
edd.ca.gov/BPO.

Watch our [Benefit Programs Online video](#) for registration instructions on a new account.

SDI Online Account Registration for Physician/Practitioners



Once you have completed your Benefit Programs Online registration, select **Log In** to navigate to the **Benefit Programs Online Login** page to complete your SDI Online registration process.



Benefit Programs Online

[En español](#)

Creating a secure account with the Employment Development Department (EDD) gives EDD customers access to online programs such as UI OnlineSM to manage Unemployment Insurance claims, and SDI Online to apply for and manage Disability Insurance and Paid Family Leave claims. Visit the [UI Online](#), [SDI Online](#), and [Benefit Programs Online](#) pages for more detailed information.

To use Benefit Programs Online, you can log in **OR** register below.

* Indicates required field

Login

If you **already have a Benefit Programs Online account or just registered**, enter your email and select Log In below.

* Email:

Log In

New Registration

If you **do not have an existing account** in Benefit Programs Online, SDI Online, and/or UI Online, select Register.

Register

Enter the email address used to register and select **Log In**.



▶ Password

To log in to Benefit Programs Online, you must verify your personal image and personal caption, and enter your password.

* Indicates required field.

Personal Image:



Personal Caption: IOU TEST

* Password:

[Forgot Password?](#)

Previous

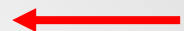
Log In

[Contact EDD](#) | [Conditions of Use](#) | [Privacy Policy](#) | [Accessibility](#)

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Enter the password you created during the registration process and select **Log In**.

If you do not recognize your personal image and caption, review the email address entered on the log in screen to make sure it is correct. Call 1-800-480-3287 for further assistance.



Benefit Programs Online

UI OnlineSM

To use UI Online, you must have filed an Unemployment Insurance (UI) claim. If you need to file a UI claim, use [eApply4UI](#).

Select UI Online to create or access a UI Online account.

To use UI Online Mobile, you must have already created a UI Online account.

UI Online

UI Online Mobile

SDI Online

SDI Online provides key services for claimants, physicians/practitioners, physician/practitioner representatives, third party administrators, and employers.

Select SDI Online to create or access an SDI Online account and file for Disability Insurance (DI) and/or Paid Family Leave (PFL) benefits.

To use SDI Online Mobile, you must have already created an SDI Online account.

SDI Online

SDI Online Mobile

Note: You will be logged out after 30 minutes on any page. Any information entered will not be saved.

To log out of Benefit Programs Online from any page, select the **Log Out** link in the top right hand corner.

After you have logged in, select the **SDI Online** link to complete your registration for SDI Online.

SDI Online Registration Option(s)

SDI Online has different accounts for each of our customer types. Read the sections below and select the option that best describes your objective for using SDI Online.

CLAIMANT

Select this option to file a Disability Insurance (DI) or Paid Family Leave (PFL) claim, access personal claim information, or view payment history. Registration is available Monday–Saturday 6 a.m. to 6 p.m. and Sunday 6 a.m. to 5:30 p.m.

You will need:

- Social Security number.
- CA driver license (CDL) or CA identification (ID) card number.
- Full legal name and correct date of birth as shown on CDL or ID card.

[Claimant Registration](#)

Note: If you do not have a CDL or ID, you will need to file your claim by mail. For instructions on how to file by mail for Disability Insurance claims visit [How to File DI By Mail](#) or for Paid Family Leave visit the [How to File PFL By Mail](#).

PHYSICIAN/PRACTITIONER

Select this option if you are a Physician/Practitioner who certifies DI or PFL claims for your patients. Registration is available Monday–Saturday 4 a.m. to 12 midnight and Sunday 4 a.m. to 9 p.m.

You will need:

- Medical license information (as filed with the California Department of Consumer Affairs).
- CA driver license (CDL) or CA identification (ID) card number.

[Physician/Practitioner Registration](#)



PHYSICIAN/PRACTITIONER REPRESENTATIVE

Select this option after a Physician/Practitioner has designated you as a representative in SDI Online. Registration is available 24 hours a day, 7 days a week.

You will need:

- To match the data entered by the Physician/Practitioner.

[Physician/Practitioner Representative Registration](#)

EMPLOYER

Select this option if you represent an employer. Registration is available 24 hours a day, 7 days a week.

You will need:

- Employer Account Number (EAN).
- ZIP Code of the employer's address on file with the EDD Tax Branch.
- Most recent Wage Report (form DE 9C).

[Employer Registration](#)

VOLUNTARY PLAN

Select this option if you represent a Voluntary Plan (VP) Employer. You will need to contact an EDD Voluntary Plan Representative in order to

You will be directed to the **SDI Online Registration Options** page.

Select the link for **Physician/Practitioner Registration**.

Physician/Practitioner: Terms and Conditions

Terms and Conditions

Please read through the entire Terms and Conditions before proceeding. The information you provide may be used to verify your identity with federal and/or state agencies. If “I Do Not Agree” is selected, you will not be able to establish an online account.

These Terms and Conditions, which include the Conditions of Use and Privacy Statements, govern the use of and access to: (i) this website (www.edd.ca.gov); and (ii) the information on or provided through this website.

If you establish an online account you are responsible for maintaining the confidentiality of your username and password, and you are responsible for all activities which you authorize under your username and password. You agree to: (i) immediately notify the Employment Development Department (EDD) of any unauthorized use of your username and password or any other breach of security; and (ii) log out from your account at the end of each session.

By registering for an online account, you agree to check your account regularly and frequently for messages from the EDD. Please note that e-mails will only be used to send notifications to log in to your account or when you request to reset your username or password. No confidential claim information will be sent via e-mail.

The information submitted by any party will be used by the Employment Development Department to carry out its responsibilities under the California Unemployment Insurance Code, which may include the sharing of the information with other entities as required by law.

These Terms and Conditions may change from time to time and it is your responsibility to check for updates. The last revision date for these Terms and Conditions is February 1, 2012.

I have read and understand all the above information and wish to continue with establishing an account in the State Disability Insurance (SDI) Online.

I Do Not Agree

I Agree

You must agree to the terms and conditions to continue. Select **I Agree**.

Contact SDI

Online
By Location
By Phone
Telephone Numbers
Automated Info
System

Physician/Practitioner: Account Verification Information

***Indicates Required Field**

If you already have an account with SDI, [log in here](#).

Personal Information

Please enter your full legal name to register.

*First Name:

Middle Name:
(If you have no middle name, leave blank.)

*Last Name:

Suffix:
(If you have no suffix, leave blank.)

*E-mail Address:

*Re-Type E-mail Address:

*Date of Birth: (MMDDYYYY)

*Last four digits of Social Security Number:

*CA Driver License or CA State ID Number:

*Re-Type CA Driver License or CA State ID Number:

Physician/ Practitioner Information

*License Type:

*Physician/Practitioner License Number:

NPI Number:

*License Expiration Date: (MMDDYYYY)

Medical School Name:

Medical School Year Graduated:

Address and Phone Number

Please enter the address and phone number as provided to the Department of Consumer Affairs.

US International

*Address Line 1:

Address Line 2:

*City:

*State:

*ZIP Code:

*Phone Number: Ext: Check here if the phone number is international
(No dashes or spaces)

Back to Top | Contact EDD | Conditions of Use | Privacy Policy | Equal Opportunity Notice

Complete the account verification information and select **Next**.

Mandatory fields are marked with a red asterisk (*).

When creating an SDI Online account, remember to:

- Enter the personal medical information as it appears in the registration with your medical board.
- Enter the mailing address the medical board has on file.

Note: You will be able to add treatment addresses once the account is created.

Physician/Practitioner: Personal Profile Information

*Indicates Required Field

Communication Preferences

Indicate below how you prefer to be notified. Some EDD forms are not available online and will be sent through the US Postal Service.

- *Preferred Communication:
- I prefer to be notified by e-mail.
 - I prefer to be notified by paper mail
 - I do not want to receive notifications. I will be reviewing the items in my message center regularly

Submit

Cancel

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On the **Personal Profile Information** page, select your preferred method of communication, then select **Submit**.

Contact SDI

SDI Online Account Registration Complete

Online

By Location

By Phone

Telephone Numbers

Automated Info

System

Account Registration Successful

Your SDI Online account has been created and a notification has been sent to you via email.

To access your SDI Online Account, select the Benefit Programs Online link below to log in.

[Benefit Programs Online](#)

A letter will be mailed to your address to confirm this account has been created.

If you selected electronic communication, a notification will also be sent to you via email.

Select the **Benefit Programs Online** link and log in to access your newly created account.

Access Your Physician/Practitioner Account



Benefit Programs Online

[En español](#)

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To use Benefit Programs Online, you can log in **OR** register below.

* Indicates required field

Login

If you **already have a Benefit Programs Online account or just registered**, enter your email and select Log In below.

* Email:

Log In

New Registration

If you **do not have an existing account** in Benefit Programs Online, SDI Online, and/or UI Online, select Register.

Register

To access your account, go directly to the Benefit Programs Online page to log in:
edd.ca.gov/BPO.

Enter the email address used to register and select **Log In**. You will then be directed to the **Password** page.



Password

To log in to Benefit Programs Online, you must verify your personal image and personal caption, and enter your password.

* Indicates required field.

Personal Image:



Personal Caption: IOU TEST

* Password:

[Forgot Password?](#)

[Previous](#)

[Log In](#)

[Contact EDD](#) | [Conditions of Use](#) | [Privacy Policy](#) | [Accessibility](#)

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UI Online

UI Online Mobile

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Select SDI Online to create or access an SDI Online account and file for Disability Insurance (DI) and/or Paid Family Leave (PFL) benefits.

To use SDI Online Mobile, you must have already created an SDI Online account.

SDI Online

SDI Online Mobile

Note: You will be logged out after 30 minutes on any page. Any information entered will not be saved.

Select **SDI Online** or **SDI Online Mobile**.

MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My Profile

Home

***Indicates Required Field**

License Information

| Licensee Name | License Number |
|---------------|----------------|
| John Feelgood | CA00000 |

Message Center

[Inbox](#) [New: 0 , Total: 0]

[Saved Drafts](#) [Total: 0]

Search

- To submit a Physician/Practitioner's Certificate (DE 2501), search by "Patient/PFL Receipt Number" or "Last 4 digits of SSN."
- To submit additional medical (DE 2525XX, DE 2547A, DE 2547D, or DE 2546), search by "Claim ID" or "Last 4 digits of SSN."
- To view forms you previously submitted, search by "My Receipt Number."
- To submit Paid Family Leave (PFL) – Doctor's Certification search by "Patient/PFL Receipt Number" and use EDD claimant's last name.

*Search By:
*Patient/PFL Last Name:
Date of Birth: (MMDDYYYY)

Once you have successfully logged into your account, you will be directed to your SDI Online **Home** page.

MAIN MENU

- [Home](#)
- [Inbox](#)
- [Saved Drafts](#)
- [Manage My Profile](#)

Home

***Indicates Required Field**

License Information

| Licensee Name | License Number |
|---------------|----------------|
| John Feelgood | CA00000 |

Message Center

[Inbox](#) [New: 0 , Total: 0]
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- To submit Paid Family Leave (PFL) – Doctor's Certification search by "Patient/PFL Receipt Number" and use EDD claimant's last name.

*Search By:

*Patient/PFL Last Name:

Date of Birth: (MMDDYYYY)

On the **Home** page, under the search section, there are four ways to begin searching for certifications and forms:

- Search by “Last 4 digits of SSN” or “Patient Receipt Number” and enter the patient’s date of birth.
- Search by “Claim ID” to submit medical extensions.
- Search by “My Receipt Number” to view forms you have submitted.
- Search by “Patient/PFL Receipt Number” to submit Paid Family Leave forms.

You must also enter the claimant’s last name to begin the search.

CA .GOV **EDD** Employment Development Department
State of California [Skip to main content](#) [Help](#) | [Logout](#)

MAIN MENU
Home
Inbox
Saved Drafts
Manage My Profile

Home

*Indicates Required Field

License Information

Licensee Name License Number

MAIN MENU
Home
Inbox
Saved Drafts
Manage My Profile

Message Center

Inbox

It is important to read all messages from EDD carefully. Select the subject hyperlink below to view the message.

No Results Found

MAIN MENU
Home
Inbox
Saved Drafts
Manage My Profile

Saved Drafts

Saved Drafts

To open and complete a form that you saved, select the Form Name. Saved drafts are stored for a limited number of days and will be automatically deleted on the date indicated. To delete a draft immediately, select the Delete action.

No Results Found

The **Main Menu** appears on most screens and has additional options.

Inbox: Access the Message Center to view messages from the EDD.

Saved Drafts: View previously saved drafts of forms that were started, but not completed or submitted.

Note: Saved Drafts are deleted after 30 days.

Add a Treatment Address

MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My Profile**

Home

*Indicates Required Field

License Information

| Licensee Name | License Number |
|---------------|----------------|
| John Feelgood | CA00000 |

Message Center

[Inbox](#) [New: 0 , Total: 0]
[Saved Drafts](#) [Total: 0]

Search

- To submit a Physician/Practitioner's Certificate (DE 2501), search by "Patient/PFL Receipt Number" or "Last 4 digits of SSN."
- To submit additional medical (DE 2525XX, DE 2547A, DE 2547D, or DE 2546), search by "Claim ID" or "Last 4 digits of SSN."
- To view forms you previously submitted, search by "My Receipt Number."
- To submit Paid Family Leave (PFL) – Doctor's Certification search by "Patient/PFL Receipt Number" and use EDD claimant's last name.

*Search By:

*Patient/PFL Last Name:

Date of Birth: (MMDDYYYY)

To add a treatment address, select **Manage My Profile** under the **Main Menu** on the **Home** page.

MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My Profile

PAGE MENU

- Change Security Questions
- Change Password
- Change Personal Image
- Manage Treatment Address**
- Manage Medical Representative

Physician/Practitioner Update Personal Profile Information

***Indicates Required Field**

Physician/ Practitioner Information

Address updates must be submitted in writing to the Medical Board with the Department of Consumer Affairs (DCA). DCA will provide EDD with your updated address when the next license validation is done.

Licensee Name: **John Feelgood**
 License Type: Physician or Surgeon (MD)
 Physician/Practitioner License Number: CA00000
 License Expiration Date: 05-31-2016
 Address: 123 Main Street Ste 1
 Anytown, CA 95148

Treatment Address

Treatment Address

You may have multiple treatment addresses associated with your account. The treatment addresses below will appear as selection options when completing online forms and will allow you to quickly provide your address without having to re-type it.

No Results Found

I do not want to receive notifications. I will be reviewing the items in my message center regularly

Add

Save **Cancel**

You will be directed to the **Physician/Practitioner Update Personal Profile Information** page.

- Select **Manage Treatment Address** from the Page Menu.
- You can add a treatment address by selecting the **Add** button.

MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My Profile

Add Modify Treatment Address

*Indicates Required Field

Add/Modify Treatment Address

US International

*Address Line 1:

Address Line 2:

*City:

*State: CA

*ZIP Code:

*Phone Number: Ext Check here if the phone number is international

Save

Cancel

On the **Add Modify Treatment Address** page, complete all fields and select **Save**.

Note: You will need to repeat this process to add all treatment addresses at which you practice.

MAIN MENU

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[Manage My Profile](#)

PAGE MENU

[Change Security Questions](#)
[Change Password](#)
[Change Personal Image](#)
[Manage Treatment Address](#)
[Manage Medical Representative](#)

Treatment Address

Treatment Address

You may have multiple treatment addresses associated with your account. The treatment addresses below will appear as selection options when completing online forms and will allow you to quickly provide your address without having to re-type it.

| Address | Phone Number | Action |
|---|--------------|---|
| 123 Main St Anytown, CA 95814 United States | 916-444-5555 | Modify Delete |

[Add](#)

Treatment addresses added are displayed on this page.

Select **Modify** or **Delete** to manage your treatment addresses.

To add additional treatment addresses, select **Add**.

Assign a Physician/Practitioner Representative

MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My Profile**

Home

***Indicates Required Field**

License Information

| Licensee Name | License Number |
|---------------|----------------|
| John Feelgood | CA00000 |

Message Center

[Inbox](#) [New: 0 , Total: 0]
[Saved Drafts](#) [Total: 0]

Search

- To submit a Physician/Practitioner's Certificate (DE 2501), search by "Patient/PFL Receipt Number" or "Last 4 digits of SSN."
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- To view forms you previously submitted, search by "My Receipt Number."
- To submit Paid Family Leave (PFL) – Doctor's Certification search by "Patient/PFL Receipt Number" and use EDD claimant's last name.

*Search By:

*Patient/PFL Last Name:

Date of Birth: (MMDDYYYY)

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Physician/practitioner representatives can complete and submit forms on behalf of the registered physician/practitioner once they have been added to the account.

To add a physician/practitioner representative, select **Manage My Profile** from the **Main Menu**.

Select **Manage Medical Representative** from the **Page Menu**.

On the **Add Delete Medical Representative** page, select **Add**

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- Manage My Profile

PAGE MENU

- Change Security Questions
- Change Password
- Change Personal Image
- Manage Treatment
- Address
- Manage Medical Representative

Physician/Practitioner Update Personal Profile Information

***Indicates Required Field**

Physician/ Practitioner Information

Address updates must be submitted in writing to the Medical Board with the Department of Consumer Affairs (DCA). DCA will provide EDD with your updated address when the next license validation is done.

Licensee Name: **John Feelgood**
License Type: Physician or Surgeon (MD)
Physician/Practitioner License Number: CA00000
License Expiration Date: 05-31-2016
Address: 123 Main St Ste 1
Anytown, CA 95814

MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My Profile

PAGE MENU

- Change Security Questions
- Change Password
- Change Personal Image
- Manage Treatment
- Address
- Manage Medical Representative

Add Delete Medical Representative

Medical Representative Information

Please select the Add button to enter a new Medical Representative. To modify or delete a Medical Representative, select the appropriate action. You are still responsible for certifying the medical forms.

| |
|------------------|
| No Results Found |
|------------------|

Add

Save Cancel

MAIN MENU

- Home
- Inbox
- Saved Drafts
- Manage My Profile

PAGE MENU

- Change Security Questions
- Change Password
- Change Personal Image
- Manage Treatment Address
- Manage Medical Representative

Add Modify Medical Representative

***Indicates Required Field**

Add Representative

*First Name:

Middle Name:
(if the medical representative has no middle name, leave blank)

*Last Name:

Suffix:
(if the medical representative has no suffix, leave blank)

*Last 4 Digits of Social Security Number:

*E-mail Address:

*Re-Type E-mail Address:

*Date of Birth: (MMDDYYYY)

*Treatment Address:

*Account Status:

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Complete the required fields and select a treatment address. Then select **Save**.



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PAGE MENU
[Change Security Questions](#)
[Change Password](#)
[Change Personal Image](#)
[Manage Treatment Address](#)
[Manage Medical Representative](#)

Add Delete Medical Representative

Medical Representative Information

Please select the Add button to enter a new Medical Representative. To modify or delete a Medical Representative, select the appropriate action. You are still responsible for certifying the medical forms.

| Name | Last 4 Digits of Social Security Number | E-mail Address | Date of Birth | Treatment Address | Account Status | Action |
|----------|---|----------------|---------------|------------------------------|----------------|--|
| Jane Doe | 1234 | Jane@email.com | 01-01-1950 | 123 Main St Anytown CA 95814 | Active | Modify Delete |

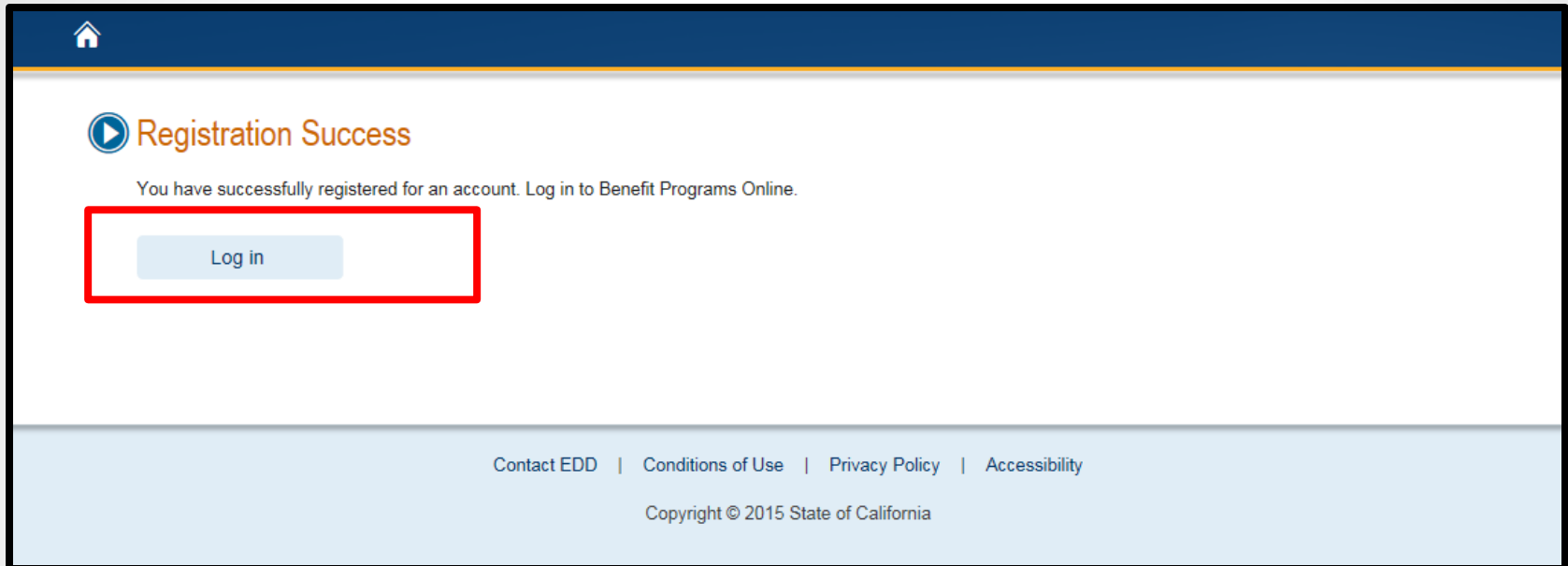
Add

Physician/practitioner representatives added are displayed on this page.

Select **Modify** or **Delete** to manage your medical representatives.

To add additional representatives, select **Add**.

SDI Online Account Registration for Physician/Practitioner Representatives



Once you have completed your Benefit Programs Online registration, select **Log In** to navigate to the Benefit Programs Online login homepage to complete your SDI Online registration process.



▶ Benefit Programs Online

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Register

Enter the email address used to register and select **Log In**.



Password

To log in to Benefit Programs Online, you must verify your personal image and personal caption, and enter your password.

* Indicates required field.

Personal Image:



Personal Caption: IOU TEST

* Password:

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UI Online

UI Online Mobile

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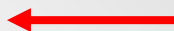
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SDI Online

SDI Online Mobile

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You will need:

- Social Security number.
- CA driver license (CDL) or CA identification (ID) card number.
- Full legal name and correct date of birth as shown on CDL or ID card.

[Claimant Registration](#)

Note: If you do not have a CDL or ID, you will need to file your claim by mail. For instructions on how to file by mail for Disability Insurance claims visit [How to File DI By Mail](#) or for Paid Family Leave visit the [How to File PFL By Mail](#).

PHYSICIAN/PRACTITIONER

Select this option if you are a Physician/Practitioner who certifies DI or PFL claims for your patients. Registration is available Monday–Saturday 4 a.m. to 12 midnight and Sunday 4 a.m. to 9 p.m.

You will need:

- Medical license information (as filed with the California Department of Consumer Affairs).
- CA driver license (CDL) or CA identification (ID) card number.

[Physician/Practitioner Registration](#)

PHYSICIAN/PRACTITIONER REPRESENTATIVE

Select this option after a Physician/Practitioner has designated you as a representative in SDI Online. Registration is available 24 hours a day, 7 days a week.

You will need:

- To match the data entered by the Physician/Practitioner.

[Physician/Practitioner Representative Registration](#)



EMPLOYER

Select this option if you represent an employer. Registration is available 24 hours a day, 7 days a week.

You will need:

- Employer Account Number (EAN).
- ZIP Code of the employer's address on file with the EDD Tax Branch.
- Most recent Wage Report (form DE 9C).

[Employer Registration](#)

VOLUNTARY PLAN

Select this option if you represent a Voluntary Plan (VP) Employer. You will need to contact an EDD Voluntary Plan Representative in order to

You will be directed to the **SDI Online Registration Options** page.

Select the link for **Physician/practitioner Representative Registration**.

Physician/Practitioner Representative: Terms and Conditions

Terms and Conditions

Please read through the entire Terms and Conditions before proceeding. The information you provide may be used to verify your identity with federal and/or state agencies. If "I Do Not Agree" is selected, you will not be able to establish an online account.

These Terms and Conditions, which include the Conditions of Use and Privacy Statements, govern the use of and access to: (i) this website (www.edd.ca.gov/); and (ii) the information on or provided through this website.

If you establish an online account you are responsible for maintaining the confidentiality of your username and password, and you are responsible for all activities which you authorize under your username and password. You agree to: (i) immediately notify the Employment Development Department (EDD) of any unauthorized use of your username and password or any other breach of security; and (ii) log out from your account at the end of each session.

By registering for an online account, you agree to check your account regularly and frequently for messages from the EDD. Please note that e-mails will only be used to send notifications to log in to your account or when you request to reset your username or password. No confidential claim information will be sent via e-mail.

The information submitted by any party will be used by the Employment Development Department to carry out its responsibilities under the California Unemployment Insurance Code, which may include the sharing of the information with other entities as required by law.

These Terms and Conditions may change from time to time and it is your responsibility to check for updates. The last revision date for these Terms and Conditions is February 1, 2012.

I have read and understand all the above information and wish to continue with establishing an account in the State Disability Insurance (SDI) Online.

I Do Not Agree

I Agree

You must agree to the terms and conditions to continue. Select **I Agree**.

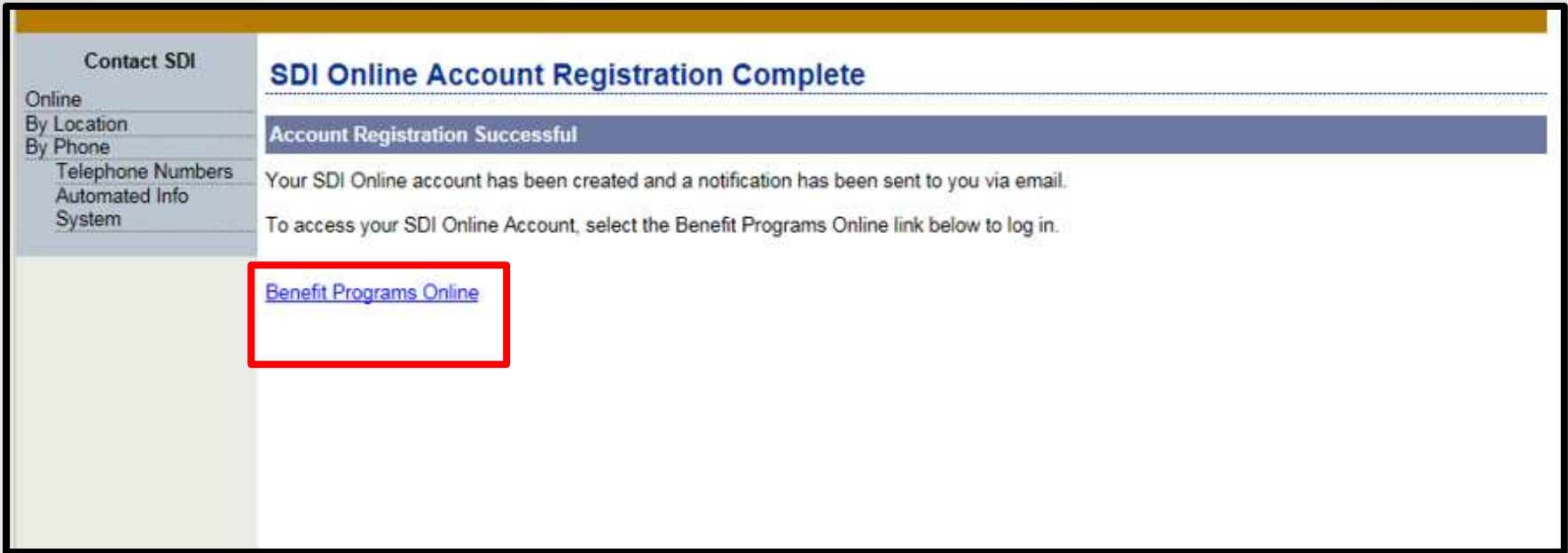
| | |
|---|---|
| Contact SDI | Physician/Practitioner Representative: Account Verification Information |
| Online | |
| By Location | |
| By Phone | *Indicates Required Field |
| Telephone Numbers | To register for a new SDI Online account, provide the following information. |
| Automated Info System | |
| | Physician/Practitioner Representative Information |
| | Please enter your name as provided to the EDD by the medical provider authorizing your account. |
| | *First Name: <input type="text"/> |
| | Middle Name: <input type="text"/> (If you have no middle name, leave blank.) |
| | *Last Name: <input type="text"/> |
| | Suffix: <input type="text"/> (If you have no suffix, leave blank.) |
| | E-mail Address: TestSNDI0700222@edd.ca.gov |
| | *Date of Birth: <input type="text"/> (MMDDYYYY) |
| | *Last four digits of Social Security Number: <input type="text"/> |
| | <input type="button" value="Next"/> <input type="button" value="Cancel"/> |
| Back to Top Contact EDD Conditions of Use Privacy Policy Equal Opportunity Notice | |

Complete the physician/practitioner representative information section. Be sure to enter your name exactly as provided to the EDD by the physician/practitioner authorizing your account, then select **Next**.

| | |
|-----------------------|--|
| Contact SDI | Physician/Practitioner Representative: Personal Profile Information |
| Online | |
| By Location | |
| By Phone | |
| Telephone Numbers | |
| Automated Info System | |
| | *Indicates Required Field |
| | Physician/Practitioner Representative Information |
| | Treatment Address: 123 Main St Anytown, CA 95814 United States |
| | *Phone Number: <input type="text"/> Ext: <input type="text"/> <input type="checkbox"/> Check here if the phone number is international (No dashes or spaces) |
| | Communication Preferences |
| | Indicate below how you prefer to be notified. Some EDD forms are not available online and will be sent through the US Postal Service. |
| | *Preferred Communication: <input checked="" type="radio"/> I prefer to be notified by e-mail. <input type="radio"/> I prefer to be notified by paper mail <input type="radio"/> I do not want to receive notifications. I will be reviewing the items in my message center regularly |
| | <input type="button" value="Submit"/> <input type="button" value="Cancel"/> |
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Verify the treatment address, enter the phone number, and select your preferred method of communication, then select **Submit**.

Note: The physician/practitioner can change the fields that a physician/practitioner representative cannot.



The screenshot shows a web page titled "SDI Online Account Registration Complete". On the left is a navigation menu with "Contact SDI" at the top, followed by "Online", "By Location", "By Phone", "Telephone Numbers", "Automated Info", and "System". The main content area has a blue header "SDI Online Account Registration Complete" and a dark blue bar "Account Registration Successful". Below this, text states: "Your SDI Online account has been created and a notification has been sent to you via email. To access your SDI Online Account, select the Benefit Programs Online link below to log in." A red box highlights the blue underlined link "Benefit Programs Online".

A letter will be mailed to the physician's/practitioner's address to confirm this account has been created.

If you selected electronic communication, a notification will also be sent to you via email.

Select the **Benefit Programs Online** link and log in to begin working on a physician/practitioner account.



Benefit Programs Online

[En español](#)

Creating a secure account with the Employment Development Department (EDD) gives EDD customers access to online programs such as UI OnlineSM to manage Unemployment Insurance claims, and SDI Online to apply for and manage Disability Insurance and Paid Family Leave claims. Visit the [UI Online](#), [SDI Online](#), and [Benefit Programs Online](#) pages for more detailed information.

To use Benefit Programs Online, you can log in **OR** register below.

* Indicates required field

Login

If you **already have a Benefit Programs Online account or just registered**, enter your email and select Log In below.

* Email:

New Registration

If you **do not have an existing account** in Benefit Programs Online, SDI Online, and/or UI Online, select Register.

Enter the email address used to register and select **Log In**. You will then be directed to the **Password** page.



▶ Password

To log in to Benefit Programs Online, you must verify your personal image and personal caption, and enter your password.

* Indicates required field.

Personal Image:



Personal Caption: IOU TEST

* Password:

[Forgot Password?](#)

Previous

Log In

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Enter the password you created during the registration process and select **Log In**.

If you do not recognize your personal image and caption, review the email address entered on the login screen to make sure it is correct. Call 1-800-480-3287 for further assistance.

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Choose Physician/Practitioner

Physician/Practitioner Representative Choose Physician/Practitioner

You are authorized to perform work in the State Disability Insurance (SDI) Online system for the physician/practitioner(s) listed below. Please select the physician/practitioner for which you wish to perform work. You may only perform work for one physician/practitioner per log in. You will need to log out to select a different physician/practitioner.

| Physician/Practitioner | New Action Required | Total Action Required | Saved Drafts |
|------------------------------|---------------------|-----------------------|--------------|
| EUGENE CHU | 0 | 0 | 0 |
| PHILIP CHIOU | 0 | 0 | 0 |

You may now select the physician/practitioner account you wish to work on.

Submit a DE 2501 Part B – Physician's/Practitioner's Certificate

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Home

*Indicates Required Field

License Information

| Licensee Name | License Number |
|---------------|----------------|
| John Feelgood | CA00000 |

Message Center

[Inbox](#) [New: 0 , Total: 0]
[Saved Drafts](#) [Total: 0]

Search

- To submit a Physician/Practitioner's Certificate (DE 2501), search by "Patient/PFL Receipt Number" or "Last 4 digits of SSN."
- To submit additional medical (DE 2525XX, DE 2547A, DE 2547D, or DE 2546), search by "Claim ID" or "Last 4 digits of SSN."
- To view forms you previously submitted, search by "My Receipt Number."
- To submit Paid Family Leave (PFL) – Doctor's Certification search by "Patient/PFL Receipt Number" and use EDD claimant's last name.

*Search By:

*Patient/PFL Last Name:

Date of Birth: (MMDDYYYY)

Last 4 digits of SSN

Physicians/Practitioners

On the **Home** page, under the **Search** section, there are two ways to begin searching for the DE 2501B to find your patient's claim:

- Search by "Patient Receipt Number."
- Search by the last four digits of the patient's SSN and Date of Birth.

You must also enter the patient's last name to begin the search.

In order to submit the DE 2501 Part B online, the patient must have already submitted the DE 2501 Part A – Claimant's Statement.



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Choose Physician/Practitioner

Physician/Practitioner Representative Choose Physician/Practitioner

You are authorized to perform work in the State Disability Insurance (SDI) Online system for the physician/practitioner(s) listed below. Please select the physician/practitioner for which you wish to perform work. You may only perform work for one physician/practitioner per log in. You will need to log out to select a different physician/practitioner.

| Physician/Practitioner | New Action Required | Total Action Required | Saved Drafts |
|-------------------------------|---------------------|-----------------------|--------------|
| John Feelgood | 0 | 0 | 0 |

Physician/Practitioner Representatives

On the **Home** page, select the physician/practitioner you are submitting the DE 2501B on behalf of.

You may select only one physician/practitioner at a time.

You may switch to a different physician/practitioner account by selecting **Home** from the **Main Menu** and selecting **Choose Physician/Practitioner**.

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Home

***Indicates Required Field**

License Information

| Licensee Name | License Number |
|---------------|----------------|
| John Feelgood | CA00000 |

Message Center

[Inbox](#) [New: 0 , Total: 0]
[Saved Drafts](#) [Total: 0]

Search

- To submit a Physician/Practitioner's Certificate (DE 2501), search by "Patient/PFL Receipt Number" or "Last 4 digits of SSN."
- To submit additional medical (DE 2525XX, DE 2547A, DE 2547D, or DE 2546), search by "Claim ID" or "Last 4 digits of SSN."
- To view forms you previously submitted, search by "My Receipt Number."
- To submit Paid Family Leave (PFL) – Doctor's Certification search by "Patient/PFL Receipt Number" and use EDD claimant's last name.

*Search By:

*Patient/PFL Last Name:

Date of Birth: (MMDDYYYY)

Claim(s) Pending Physician/Practitioner's Certificate (DE 2501 or DE 2501F)

| Receipt Number | Patient/PFL Name | Date Disability Began | Action |
|----------------------------------|------------------|-----------------------|---|
| R100000000291737 | Oliver October | 10-02-2014 | Submit Physician/Practitioner Certificate |

Claim(s) Available to Submit Additional Medical Information (DE 2525XX, DE 2547A, DE 2547D, or DE 2546)

No Results Found

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Select a preferred search method from the **Search By** drop down menu.

Verify the information in the **Search Results** section matches the patient's records.

The **Receipt Number** link will allow you to view what the patient submitted on their portion of the DE 2501 Part A – Claimant's Statement.

Select the **Submit Physician/Practitioner Certificate** link under the action column.

Note: If the certificate is already submitted by another user (i.e., physician/practitioner representative), the **Submit Physician/Practitioner Certificate** link will not be available.

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View Claimant Portion

View Claimant DE 2501

Refer to the *Claim for Disability Insurance (DI) Benefits* (DE 2501) Claimant's Statement while completing this form. To open the Claimant's Statement, select the hyperlink below and it will open in a new window.

[View the Claim for Disability Insurance \(DI\) Benefits Claimant \(DE 2501\)](#)

Next **Cancel**

On the **View Claimant Portion**, you may select the link to view the claimant portion of the form.

Select **Next** to complete the certificate.

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Treatment Address

1 → 2 → 3 → 4
 Treatment Address Patient Information Claim Information/Declaration

You are currently on Step 1 Treatment Address

Section 2B - Treatment Address

Select the address where the patient was treated. If the patient was treated at an address other than those shown below, select 'Not Found' and you will be prompted to enter a new treatment address.

| Address | Action |
|---|------------------------|
| 123 Main St Anytown, CA 95814 United States | Select |

Previous **Not Found** **Cancel**

On the **Treatment Address** page, select the treatment address of where the patient is being treated.

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[Inbox](#)
[Saved Drafts](#)
[Manage My Profile](#)

1
Treatment Address

2
Patient Information

3
Claim Information

4
Declaration

You are currently on Step 3 Claim Information

***Indicates Required Field**

Section 4A - Claim Information

*Date Disability Began: (MMDDYYYY)

Indicate if the disability was caused by accident or trauma; and if so, indicate the date the accident or trauma occurred below:

*Accident or trauma? Yes No Date occurred: (MMDDYYYY)

For non-pregnancy related claims, you must provide the following date or indicate the disability is permanent.

Date you released or anticipate releasing patient to return to his/her regular or customary work: (MMDDYYYY)

Check here to indicate patient's disability is permanent and you never anticipate releasing patient to return to his/her regular or customary work:

Enter the ICD Diagnosis Code and version for the primary disabling condition that prevents the patient from performing his/her regular or customary work below:

*ICD Diagnosis Code: *Diagnosis Code Version:

ICD Diagnosis Code(s) for Secondary Disabling Condition(s):

| | |
|--|---|
| ICD Diagnosis Code: <input type="text"/> | Diagnosis Code Version: <input type="text" value="Select"/> |
| ICD Diagnosis Code: <input type="text"/> | Diagnosis Code Version: <input type="text" value="Select"/> |
| ICD Diagnosis Code: <input type="text"/> | Diagnosis Code Version: <input type="text" value="Select"/> |

*Diagnosis - If no diagnosis has been determined, enter a detailed statement of symptoms:

Findings - State nature, severity, and extent of the incapacitating disease or injury, include any other disabling conditions:

Type of treatment/medication rendered to patient:

If the patient was hospitalized, enter the date of entry, date of discharge and whether the patient is still hospitalized below:

Date of entry: (MMDDYYYY) Date of discharge: (MMDDYYYY)

Patient is still hospitalized? Yes No Check here if the patient is deceased:

SDI Online will accept valid ICD-9 and ICD-10 codes.

If the patient's disability is diagnosed as permanent and you have selected the "permanent disability" box, you do **not** need to provide a date in the "Date you released or anticipate releasing patient to return to his/her regular or customary work" field.

In the "Findings" field, please provide a detailed description of why you consider the disability to be permanent.

Enter type and date of surgery/procedure most recently performed or to be performed below::
 Type: Date: (MMDDYYYY)

Enter the ICD Procedure Code and version for surgery/procedure(s) planned or performed below:

ICD Procedure Code: Procedure Code Version:

ICD Procedure Code: Procedure Code Version:

ICD Procedure Code: Procedure Code Version:

ICD Procedure Code: Procedure Code Version:

Enter the CPT code for surgery/procedure(s) planned or performed below:

CPT Code: CPT Code:

CPT Code: CPT Code:

Was the patient unable to work immediately prior to the surgery or procedure? Yes No

If "Yes," please provide the first date the patient was unable to work prior to the surgery or procedure: (MMDDYYYY)

*Was this disabling condition caused and/or aggravated by the patient's regular or customary work? Yes No

*Are you completing this form for the sole purpose of referral/recommendation to an alcoholic recovery home or drug-free facility (as indicated by the patient on the DE 2501 Claim for Disability Insurance (DI) Benefits Claimant's Statement)? Yes No

Date your patient became a resident of a drug or alcohol facility (if known): (MMDDYYYY)

*Would disclosure of the information on this form to your patient be medically or psychologically detrimental? Yes No

*Is this a pregnancy related claim? Yes No

Section 5 - Pregnancy

Estimated Delivery Date: (MMDDYYYY) Pregnancy End Date (if applicable): (MMDDYYYY)

If this patient has not delivered and you do not anticipate releasing the patient to return to regular or customary work prior to the estimated delivery date, provide estimates for the number of days you anticipate the patient will be disabled after delivery for both of the following delivery types:

Vaginal delivery: Cesarean delivery:

If this patient has delivered, indicate type of delivery and any complications as applicable.

Type of delivery:

If pregnancy is/was abnormal, state the complication(s) causing maternal disability:

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Physicians/practitioners can provide an estimated number of days they anticipate the patient to be disabled postpartum.

➤ Example: If the physician/practitioner allows the patient 6-8 weeks of postpartum disability, depending on the delivery type, then:

- Enter the number 42 in the Vaginal Delivery field (6 weeks x 7 days a week = 42)

OR

- Enter the number 56 in the Cesarean Delivery field (8 weeks x 7 days a week = 56).

Select **Next**.

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ICD Code Summary

1 → 2 → 3 → 4
Treatment Address Patient Information Claim Information Declaration

You are currently on Step 3 Claim Information

Section 4B - ICD Code Summary

| Type | ICD Code | Version | Diagnosis | Action |
|------------------------|----------|---------|-----------------------------|--------|
| Primary Diagnosis Code | 222.2 | ICD-9 | BENIGN NEOPLASM OF PROSTATE | Delete |

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Verify the ICD code(s) is correct for the claim and select **Next**.

If it is not correct, select **Delete** and re-input the correct code(s) in the **Claim Information** section.

Certification



You are currently on Step 4 Declaration

*Indicates Required Field

Section 7 - Certification

* I certify under penalty of perjury that the patient is unable to perform his/her regular or customary work because of the listed disabling condition(s). I have performed a physical examination and/or treated the patient within my scope of practice as an authorized physician or practitioner pursuant to California Unemployment Insurance Code Section 2708.

To review your information before you submit, select the hyperlink below. Your information will display below the Claimant's Statement.

[View the Claim for Disability Insurance \(DI\) Benefits Physician/Practitioner Certification \(DE 2501\)](#)

Previous

Submit

Save as Draft

Cancel

Once the form is completed, select the box in the **certification** section to authorize an electronic signature. Before submitting the form, you may view the form by selecting the link at the bottom of the page.

Select **Submit**. You will be directed to the **Confirmation** page and provided a form receipt number.

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Confirmation

Confirmation

Please print this page for your records. If a printer is unavailable at this time, please record the Form Receipt Number below. The Form Receipt Number is required to retrieve a copy of the *Claim for Disability Insurance (DI) Benefits* (DE 2501). You will not be able to access your confirmation page and Form Receipt Number after this window is closed.

Form Receipt Number: [R10000000291738](#)

On the **Confirmation** screen, select the **Form Receipt Number** link to open a PDF printer-friendly view of the information that is submitted.

Submit an online DE 2525XX
Supplemental Medical Certificate
for Continued Benefits

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***Indicates Required Field**

License Information

| Licensee Name | License Number |
|---------------|----------------|
| John Feelgood | CA00000 |

Message Center

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Search

- To submit a Physician/Practitioner's Certificate (DE 2501), search by "Patient/PFL Receipt Number" or "Last 4 digits of SSN."
- To submit additional medical (DE 2525XX, DE 2547A, DE 2547D, or DE 2546), search by "Claim ID" or "Last 4 digits of SSN."
- To view forms you previously submitted, search by "My Receipt Number."
- To submit Paid Family Leave (PFL) – Doctor's Certification search by "Patient/PFL Receipt Number" and use EDD claimant's last name.

*Search By:

*Patient/PFL Last Name:

Date of Birth: (MMDDYYYY)

Search Results

| Claim ID | Patient/PFL Name | Date of Birth | Claim Effective Date | Claim Type |
|------------------------------|------------------|---------------|----------------------|----------------------|
| D11000021843 | Jane Doe | 10-20-1975 | 12-15-2012 | Disability Insurance |

On the **Home** page, to submit a DE 2525XX – Supplemental Medical Certificate:

Select a preferred search method from the **Search By** drop down menu.

Verify the information in the **Search Results** section matches the patient's records.

Then select the **Claim ID** link.

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Claim Summary

Claim Summary

Claimant Name: **Jane Doe** Claim ID: DI-1000-021-843
Claim Effective Date: 12-15-2012

My Message Center Regarding Jane Doe

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[Saved Drafts](#) [Total: 0]

My Forms Available to Submit for Jane Doe

Below is a list of forms available for submission. Please note that not all forms will be available at all times. If a form for the same dates has already been submitted or mailed, do not submit a duplicate form. Please allow 5-7 business days for the form to be processed.

[2525XX Supplemental Medical Cert](#)

My Forms Submitted for Jane Doe

No Results Found

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Under the **My Forms Available to Submit** section, select the **2525XX Supplemental Medical Cert** link.

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Physician/Practitioner Supplementary Certificate (Part 1)

*Indicates Required Field

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Physician/Practitioner Supplementary Certificate (Part 2)

*Indicates Required Field

Section 4B - Physician/Practitioner's Supplementary Certificate

*Was the patient hospitalized? Yes No

If "Yes," provide the following:

Date of Entry: (MMDDYYYY)

Date of Discharge: (MMDDYYYY)

Check here if patient is still hospitalized

*Was surgery/procedure performed, or will a surgery/procedure be performed? Yes No

If "Yes," type of surgery/procedure:

Date of surgery/procedure: (MMDDYYYY)

Enter the ICD Procedure Code and version for the surgery/procedure(s) planned or performed below:

| | |
|--|---|
| ICD Procedure Code: <input type="text"/> | Procedure Code Version: <input type="text" value="Select"/> |
| ICD Procedure Code: <input type="text"/> | Procedure Code Version: <input type="text" value="Select"/> |
| ICD Procedure Code: <input type="text"/> | Procedure Code Version: <input type="text" value="Select"/> |
| ICD Procedure Code: <input type="text"/> | Procedure Code Version: <input type="text" value="Select"/> |

Enter the CPT Code for the surgery/procedure(s) planned or performed below:

| | |
|--------------------------------|--------------------------------|
| CPT Code: <input type="text"/> | CPT Code: <input type="text"/> |
| CPT Code: <input type="text"/> | CPT Code: <input type="text"/> |

Present estimated date patient will be able to perform his/her regular or customary work: (MMDDYYYY)

Check here to indicate patient's disability is permanent and you never anticipate releasing patient to return to his/her regular or customary work.

*Would the disclosure of this information to your patient be medically or psychologically detrimental? Yes No

Previous **Next** **Save as Draft** **Cancel**

Complete the **Physician/Practitioner Supplementary Certificate** parts and select **Next**.

Mandatory fields are marked with a red asterisk (*).

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Submit Form

Section 5 - Certification

Submitted by **John Feelgood**

All Physicians (Medical or Osteopathic Physician and Surgeon, Chiropractor, Dentist, Podiatrist, Optometrist, Psychologist)

I certify under penalty of perjury that the patient is unable to perform his/her regular or customary work because of the disabling condition(s) listed above and I have treated the patient within my scope of practice.

Nurse Practitioner

I certify under penalty of perjury that the patient is unable to perform his/her regular or customary work because of the disabling condition(s) listed above and I have treated the patient within my scope of practice. If for a condition other than a normal pregnancy or delivery, I certify that I have performed a physical examination and have collaborated with a physician and surgeon.

Registrar of a County Hospital in California or Medical Officer of a US Government Medical Facility

I certify under penalty of perjury that the patient is unable to perform his/her regular or customary work because of the disabling condition(s) listed above and these conditions are shown by the patient's hospital chart.

Other

Title of person if not covered above (must be able to legally certify to a disability):

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Once the form is completed, select the box in the **certification** section that best describes your role to authorize an electronic signature.

Before submitting the form, you may view the form by selecting the link at the bottom of the page.

Select **Submit**. You will be directed to the **Confirmation** page and provided a form receipt number.

Note: Physician/practitioner representatives submitting the DE 2525XX on behalf of the physician/practitioner should select the **All Physicians** box.

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Confirmation

Form Successfully Submitted

Please print this page for your records. If a printer is unavailable at this time, please record the Form Receipt Number below. The Form Receipt Number is required to retrieve a copy of the *Physician/Practitioner's Supplementary Certificate* (DE 2525XX). You will not be able to access your confirmation page and Form Receipt Number after this window is closed.

Form Receipt Number: [R10000000291751](#)

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On the **Confirmation** screen, select the **Form Receipt Number** link to open a PDF printer-friendly view of the information that is submitted.

Submit a Physician/practitioner Certificate for a PFL Care Claim

CA .GOV EDD Employment Development Department State of California [Skip to main content](#) [Help](#) | [Logout](#)

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Home

*Indicates Required Field

License Information

| Licensee Name | License Number |
|---------------|----------------|
| John Feelgood | CA12345 |

Message Center

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Search

- To submit a Physician/Practitioner's Certificate (DE 2501), search by "Patient/PFL Receipt Number" or "Last 4 digits of SSN."
 - To submit additional medical (DE 2525XX, DE 2547A, DE 2547D, or DE 2546), search by "Claim ID" or "Last 4 digits of SSN."
 - To view forms you previously submitted, search by "My Receipt Number."
 - To submit Paid Family Leave (PFL) – Doctor's Certification search by "Patient/PFL Receipt Number" and use EDD claimant's last name.

Search By:
 *Patient/PFL Last Name:
 Date of Birth: (MMDDYYYY)

Search Results

| Receipt Number | Patient/PFL Name | Date of Birth | Action |
|---------------------------------|------------------|---------------|---|
| R10000000012345 | Jane Doe | 04-18-1979 | Submit Physician/Practitioner Certificate |

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On the **Home** page, under the **search** section, you may search for your patient's care provider's PFL claim:

- Search by "Patient/PFL Receipt Number" to submit PFL forms for your patient's care provider.
- Search by the last four digits of the patient's SSN, date of birth, and last name.

You must also enter the patient's care provider's last name to begin the search.

Note: In order to submit the physician/practitioner portion of the DE 2501F online, the patient's care provider must have already submitted their part of the DE 2501F.

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View Claimant Portion

*Indicates Required Field

View Claimant DE 2501F

If the person identified below (care recipient) is NOT your patient, do not complete or submit this form. To view the form information submitted by your patient's care provider, please select the hyperlink below.

[View Claim for Paid Family Leave \(PFL\) Benefits \(DE 2501F\) for Care](#)

Claimant (Care Provider) Name: **Johnny Johnson**
Claimant Social Security Number: XXX-XX-1222

Patient (Care Recipient) Name: Nag N Spouse
Patient Date of Birth: 02-14-1971

*Do you have the patient's (care recipient's) Health Insurance Portability and Accountability Act (HIPAA) authorization to submit their medical information to EDD? Yes No

Next

Cancel

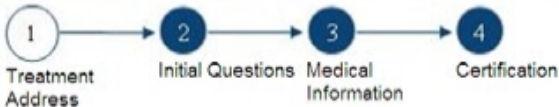
In the **View Claimant DE 2501F** section, you may select the link to view the claimant portion of the form.

Select **Next** to complete the certificate.

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Treatment Address



You are currently on Step 1 Treatment Address

Treatment Address

Select the address where the patient (care recipient) was treated. If the patient (care recipient) was treated at an address other than those shown below, select 'Not Found' and you will be prompted to enter a new treatment address.

You should only submit this form online if you have used your California medical license to treat the patient (care recipient).

| Address | Action |
|--|------------------------|
| 11000 Main St Palo Alto, CA 94301-3419 United States | Select |
| 800 D St Sacramento, CA 95814-0716 United States | Select |
| 800 D St Sacramento, CA 95814-0716 United States | Select |

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[Cancel](#)

On the **Treatment Address** page, select the treatment address of where the patient is being treated.

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Initial Questions

You are currently on Step 2 Initial Questions

***Indicates Required Field**

Physician/ Practitioner Information

Name: **John Feelgood** State License Number: CA12345
Treatment Address: 1000 Main St State of Licensure: CA
Palo Alto, CA 94301-3419
United States

*Phone Number: Ext: Check here if the phone number is international
(No dashes or spaces)

Type of Physician/Practitioner: Physician or Surgeon (MD)
Specialty (if any):

Care Required Information

Claimant (Care Provider) Name: John Johnson
Claimant Social Security Number: XXX-XX-1222

Patient (Care Recipient) Name: Sony Kittu
Patient Date of Birth: 05-06-1982

*Does your patient (care recipient) require care by the Paid Family Leave claimant (care provider) entered above? Yes No

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Verify the information showing is correct and complete the **Physician/Practitioner Information** section and select **Next**.

Mandatory fields are marked with a red asterisk (*).

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Medical Information

You are currently on Step 3 Medical Information

*Indicates Required Field

Medical Information

Enter the ICD Diagnosis Code and version for the primary serious health condition for which the patient (care recipient) requires care from the claimant (care provider)

*ICD Diagnosis Code:

*Diagnosis Code Version:

Secondary ICD Code(s) and Version(s)

ICD Code:

Code Version:

ICD Code:

Code Version:

ICD Code:

Code Version:

*Diagnosis, or if not determined, a detailed statement of symptoms:

Date patient's condition commenced: (MMDDYYYY)

*First date care needed: (MMDDYYYY)

Date you estimate patient will no longer require care by the claimant: (MMDDYYYY)

Permanent Care Required

Date you expect recovery: (MMDDYYYY)

Never

Approximately how many total hours per day will patient (care recipient) require care by a Paid Family Leave claimant (care provider)

*Hours:

Comments:

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SDI Online will accept valid ICD-9 and ICD-10 codes.

If the patient's disability is diagnosed as permanent, select the **Permanent Care Required** box.

Complete all applicable fields, then select **Next**.

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Certification

You are currently on Step 4 Certification

***Indicates Required Field**

Detrimental Medical

*Would disclosure of the medical information on this certificate be medically or psychologically Yes No detrimental to your patient?

Certification

* As a Physician or Nurse Practitioner: I certify under penalty of perjury that, I have treated this patient within the scope of my practice and that the patient has a serious health condition that warrants the care of a care provider and that this Doctor's Certificate truly describes the patient's condition, the need for care and the estimated duration for which care is needed. If I am a Nurse Practitioner certifying a condition other than normal pregnancy or delivery, I additionally certify I have performed a physical examination and have collaborated with a physician and surgeon. If I am a Registrar of a County Hospital in California or a medical officer of a US government medical facility, I certify that the patient's serious health condition is shown in the patient's hospital chart.

To review the information you have entered, right click on the hyperlink and select "Open in New Window." Then select Save.

[View Claim for Paid Family Leave \(PFL\) Benefits \(DE 2501F\) for Care](#)

[Previous](#)

Submit

Save as Draft

Cancel

Once the form is completed, select the box in the **Certification** section to authorize an electronic signature.

Before submitting the form, you may view the form by selecting the link at the bottom of the page.

Select **Submit**. You will be directed to the **Confirmation** page and provided a form receipt number.

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Confirmation

Confirmation

The form has been successfully submitted. Please record the receipt number for your records. You may access this form from your home page by searching with the receipt number.


Form Receipt Number: [R10000000012345](#)


On the **Confirmation** screen, select the **Form Receipt Number** link to open a PDF printer-friendly view of the information that is submitted.

Submit a Paper Claim Form

To avoid delays in claims processing, complete the form as follows:

- Use black ink only.
- Type or write clearly **within** the boxes provided.
- Fill out only the physician's/practitioner's portion of the form:
 - Part B of the *Claim for Disability Insurance (DI) Benefits* (DE 2501)
 - Page D of the *Claim for Paid Family Leave (PFL) Benefits* (DE2501F)
- Provide only one medical license number. If licensed in multiple scopes of practice, use the license for the type of disability you are certifying for.
- Do not fax or photocopy the form.
- Mail the completed form to the EDD in the pre-addressed envelope provided.
- Do not mail this form to the EDD if you have already submitted this claim online.


Claim for Paid Family Leave (PFL) Benefits
 State of California Employment Development Department


 2501F10161

PART A - STATEMENT OF CLAIMANT CARE OR BONDING PROVIDER

A1. YOUR SOCIAL SECURITY NO. _____ A2. YOUR DATE OF BIRTH _____
M A D D Y Y Y Y

A3. LANGUAGE YOU PREFER TO USE
 ENGLISH ESPAÑOL OTHER (PRINT BELOW) _____

A4. YOUR LEGAL NAME FIRST NAME _____ A5. YOUR GENDER _____
MALE FEMALE

A6. YOUR TELEPHONE NUMBER _____ A7. _____

A8. YOUR MAILING ADDRESS (FOR RECEIVING MAIL AT A PRIVATE MAIL)
 CITY _____

A9. NAME OF YOUR EMPLOYER _____
 CITY _____

A10. DATE YOU LAST WORKED _____ A11. DATE YOU Y PFL CLAIM Y _____
M M D D Y Y Y Y M M D D

A14. WHY DID YOU OR WILL YOU REDUCE YOUR WORK H _____
CARE FOR BOND WITH
FAMILY MEMBER CHILD OTHER (EXPLAIN)

A16. LEGAL NAME OF PERSON FOR WHOM YOU ARE C _____

A17. THE ABOVE-NAMED CARE OR BONDING RECIPIEN _____
REGISTERED DOMESTIC PARENT
CHILD SPOUSE PARTNER PARENT IN-LAW

A18. IS ANY OTHER FAMILY MEMBER READY, WILLING, AVAILABLE TO PROVIDE CARE FOR THE SAME PER CLAIMIN _____
NO YES

A20. DO YOU HAVE MORE THAN ONE EMPLOYER? _____ A21. IF YOUR EM DURING YO _____
NO YES SICK VACANTIC

A24. AT ANY TIME DURING YOUR PFL LEAVE, WERE YOU CONVICTED OF VIOLATING A LAW OR ORDINAN _____

A25. Declaration and Signature. By my signature on this claim (bonding with the care recipient named above), I authorize EDD to respectively listed in Part C and Part D of this claim. (3) authorize on information as stated in the "Information Collection and Access" provisions of California law pursuant to the implementation or time of the and below true, correct, and complete. I agree that photocopies of this form of fifteen years from the date of my signature or the effective Claimant's Signature (DO NOT PRINT) _____

*If your signature is made by mark (X), it must be attested by a Witness Signature and Address.

DE 2501F Rev. 2 (10-16)

CARE RECIPIENT'S AUTHORIZATION FOR DISCLOSURE OF PERSONAL-HEALTH INFORMATION

I authorize my physician or practitioner, as identified on Part D of this claim, to disclose my current personal-health information to my care provider, as identified on Part A of this claim, and to the California Employment Development Department (EDD).

I understand that such information includes a diagnosis and prognosis of my current condition, the date it commenced, and an estimation of the amount of care that I require from my care provider as a result of my current condition. I further understand that disclosure of my personal-health information may include my AIDS/HIV status, drug or alcohol addiction, or any other physical or mental condition.

I understand that EDD may disclose this information as authorized by the California Unemployment Insurance Code and that such re-disclosed information may no longer be protected. I agree that photocopies of the authorization form in conjunction with my signature on Page 3 in Item 6 of Part C shall be as valid as the original.

I understand that unless I inform EDD in writing at P.O. Box 989315, West Sacramento, CA 95798-9315, that I wish to revoke this authorization, it will be valid for 10 years from the date EDD receives it or the effective date of this claim, whichever is later. I understand that I have the right to receive a copy of an authorization form from EDD if I request one in writing.

I make this authorization to support my care provider's claim for Paid Family Leave benefits. I understand that I may not revoke my authorization to avoid prosecution or to prevent EDD's recovery of monies to which it is legally entitled.

WE CANNOT PROCESS THIS CLAIM UNLESS YOU SIGN BOTH THIS PAGE AND PAGE 3 IN ITEM C6 OF PART C.

 Care recipient's name (Print your name)

 Care recipient's signature (Sign your name)

 Date signed

DE 2501F Rev. 2 (10-16) page 2 of 4
OSP 16 140887

Claim for Paid Family Leave (PFL) Benefits (DE 2501F)

Part A -Statement of Claimant, page 1.

Complete the information, including whether this is for a bonding or care claim. Make sure to sign and date the form.

Care Recipient Authorization for Disclosure of Personal-Health Information, page 2.

The person receiving care, or his/her authorized agent, must sign the bottom of this page.



2501F10162

PART B – BONDING CERTIFICATION (TO BE COMPLETED BY PERSON CLAIMING PFL BENEFITS TO BOND WITH A CHILD)

B1. YOUR SOCIAL SECURITY NUMBER

B2. DATE OF FOSTER CARE OR ADOPTION PLACEMENT
M M D D Y Y Y Y

B3. CHILD NAMED IN B3 IS MY
BIOLOGICAL CHILD STEPCHILD FOSTER CHILD ADOPTED CHILD OTHER

B4. YOUR LEGAL LAST NAME (NEEDED IN CASE PAGES OF THIS CLAIM BECOME SEPARATED)

B5. CHILD'S SOCIAL SECURITY NUMBER (IF AVAILABLE)

B6. CHILD'S DATE OF BIRTH
M M D D Y Y Y Y

B7. CHILD'S GENDER
MALE FEMALE

B8. LEGAL NAME OF CHILD (FIRST MIDDLE INITIAL LAST)

B9. CHILD'S RESIDENCE ADDRESS (IF DIFFERENT FROM CLAIMANT'S)
CITY STATE/PROV. ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)

B10. AS EVIDENCE OF THE RELATIONSHIP IN B3, CHECK ONE OF THE FOLLOWING AND ATTACH A COPY OF THE DOCUMENT CHECKED.
(DO NOT SEND ORIGINAL DOCUMENT. IT WILL NOT BE RETURNED.)

CHILD'S BIRTH CERTIFICATE ADOPTIVE PLACEMENT AGREEMENT, AD-907

DECLARATION OF PATERNITY, CS-909 INDEPENDENT ADOPTION PLACEMENT AGREEMENT, AD-924

FOSTER CARE PLACEMENT RECORD, SOC-815 OTHER

B11. Declaration and Signature. By my signature on this bonding certification, I authorize the medical provider, adoption agency, adoption party(ies), or foster care placement agency to disclose in the Employment Development Department all facts concerning the birth, adoption, or foster care placement of the above-named child. I understand that willfully making a false statement or concealing a material fact in order to obtain payment of benefits is a violation of California law punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement, including any accompanying statements or documents, is to the best of my knowledge and belief true, correct, and complete. I agree that photocopies of this authorization shall be as valid as the original, and I understand that authorizations contained in this claim statement are granted for a period of fifteen years from the date of my signature or the effective date of the claim, whichever is later.

Original Signature of Bonding Claimant – RUBBER STAMP IS NOT ACCEPTABLE

Date Signed | MM | DD | YYYY

PART C – STATEMENT OF CARE RECIPIENT (MAY BE COMPLETED BY CLAIMANT IF CARE RECIPIENT IS MENTALLY OR PHYSICALLY UNABLE TO DO SO. MUST BE SIGNED BY CARE RECIPIENT OR CARE RECIPIENT'S AUTHORIZED REPRESENTATIVE.)

C1. RECIPIENT'S DATE OF BIRTH
M M D D Y Y Y Y

C2. RECIPIENT'S TELEPHONE NUMBER

C3. RECIPIENT'S GENDER
MALE FEMALE

C4. LEGAL NAME OF CARE RECIPIENT (FIRST MIDDLE INITIAL LAST)

C5. CARE RECIPIENT'S RESIDENCE ADDRESS
CITY STATE/PROV. ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)

C6. CONFIRMATION OF MEDICAL DISCLOSURE AUTHORIZATION. I have read and signed the Care Recipient's Authorization for Disclosure of Personal-Health Information on page 2 of this claim. I understand that by signing it I have agreed to all its provisions and terms. I further understand that copies of my signature below are as valid as the original.

Care Recipient's Signature (DO NOT PRINT) Date Signed | MM | DD | YYYY

C7. Authorized Representative signing on behalf of care recipient must complete the following: I, _____, represent the care or bonding recipient in this matter as authorized by parental right power of attorney (attach copy) court order (attach copy). (For spouse or domestic partner, contact EDD.)

Authorized Representative's Signature (DO NOT PRINT) Date Signed | MM | DD | YYYY

Claim for Paid Family Leave (PFL) Benefits (DE 2501F)

Part B - Bonding Certification (bonding claims only) and Part C - Statement of Care Recipient (care claims only), page 3.

Part B – For bonding claims the claimant must complete all bonding information and sign the form.

Part C – For care claims the patient/care recipient or claimant must fill out the appropriate care information. The care recipient or their authorized representative must sign the form.

Claimant/patient will complete either Part B or Part C – but never both for one claim.

Medical certifications must be completed by a licensed physician or practitioner authorized to certify to a patient's disability/serious health condition pursuant to California Unemployment Insurance Code Section 2708.



2501F10153



INSTRUCTIONS FOR COMPLETING THIS FORM:

Please complete the information in the spaces provided in UPPER CASE using black ink. Do not use special characters (-, ., /). If handwritten, print each letter or number in a separate box. Ignore the boxes provided if using a typewriter or printer.

PART D – PHYSICIAN/PRACTITIONER'S CERTIFICATION (DO NOT COMPLETE THIS PART IF YOU ARE BONDING WITH A CHILD.)

D1. PFL CLAIMANT'S (CARE PROVIDER'S) SOCIAL SECURITY NUMBER

D2. PFL CLAIMANT'S NAME (FIRST MIDDLE INITIAL LAST)

D3. PATIENT'S DATE OF BIRTH

D4. DOES YOUR PATIENT REQUIRE CARE BY THE CLAIMANT?

D5. PATIENT'S NAME (FIRST MIDDLE INITIAL LAST)

D6. DIAGNOSIS OR, IF NOT YET DETERMINED, A DETAILED STATEMENT OF SYMPTOMS

D7. PRIMARY ICD CODE

D8. SECONDARY ICD CODES

D9. DATE PATIENT'S CONDITION COMMENCED

D10. FIRST DATE CARE NEEDED

D11. DATE YOU EXPECT RECOVERY

D12. DATE YOU ESTIMATE PATIENT WILL NO LONGER REQUIRE CARE BY THE CLAIMANT

D13. APPROXIMATELY HOW MANY TOTAL HOURS PER DAY WILL PATIENT REQUIRE CLAIMANT?

D14. WOULD DISCLOSURE OF THIS CERTIFICATE TO YOUR PATIENT BE MEDICALLY OR PSYCHOLOGICALLY DETRIMENTAL?

D15. PHYSICIAN/PRACTITIONER'S LICENSE NUMBER

D16. STATE OR COUNTRY PHYSICIAN/PRACTITIONER IS LICENSED.

D17. PHYSICIAN/PRACTITIONER'S NAME (FIRST MIDDLE INITIAL LAST)

D18. PHYSICIAN/PRACTITIONER'S ADDRESS (POST OFFICE BOX IS NOT ACCEPTABLE AS THE SOLE ADDRESS)

D19. TYPE OF PHYSICIAN/PRACTITIONER

D20. SPECIALTY (IF ANY)

D21. PHYSICIAN/PRACTITIONER'S Certification and Signature: I certify under penalty of perjury that this patient has a serious health condition and requires a care provider. I have performed a physical examination and/or treated the patient. I am authorized to certify a patient disability or serious health condition pursuant to California Unemployment Insurance Code Section 2708.

Original Signature of Attending Physician/Practitioner – RUBBER STAMP IS NOT ACCEPTABLE

PHYSICIAN/PRACTITIONER'S PHONE NO.

Date Signed (MM | DD | YYYY)

Under sections 2116 and 2122 of the California Unemployment Insurance Code, it is a violation for any individual who, with intent to defraud, falsely certifies the medical condition of any person in order to obtain disability insurance benefits, whether for the maker or for any other person, and is punishable by imprisonment and/or a fine not exceeding \$20,000. Sections 1143 and 3303 require additional administrative penalties.

Claim for Paid Family Leave (PFL) Benefits (DE 2501F)

Part D – Physician/Practitioner's Certification, page 4.

You (the physician/practitioner) must complete all patient information for care claims, including dates and diagnosis codes and you must sign the bottom of the form.

You and your claimant/patient should make sure all pages are completed and all signatures are obtained before the claim form is mailed back to the EDD for processing.

Visit www.edd.ca.gov/disability for more information about State Disability Insurance.

For help with SDI Online for physicians/practitioners,
call 1-855-342-3645

(Please do not give this number out to patients. This number is for physician/practitioners only. All other callers will be redirected.)

The EDD is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Requests for services, aids, and/or alternate formats need to be made by calling 1-866-490-8879 (voice), or through the California Relay Service at 711.