SDI Online Tutorial:

Physician/Practitioner and Physician/Practitioner Representative Registration, Online Access Information, and Form Submission

Employment Development Department
State of California

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.

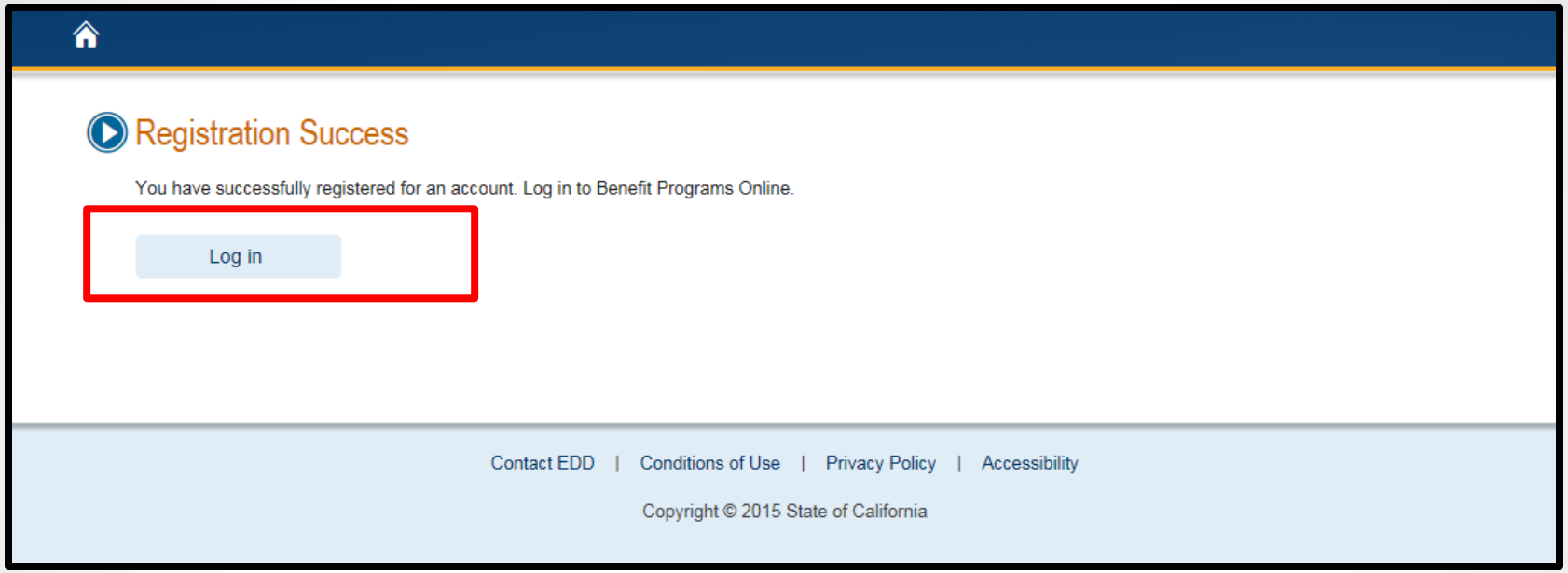
New Registration
Benefit Programs Online

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

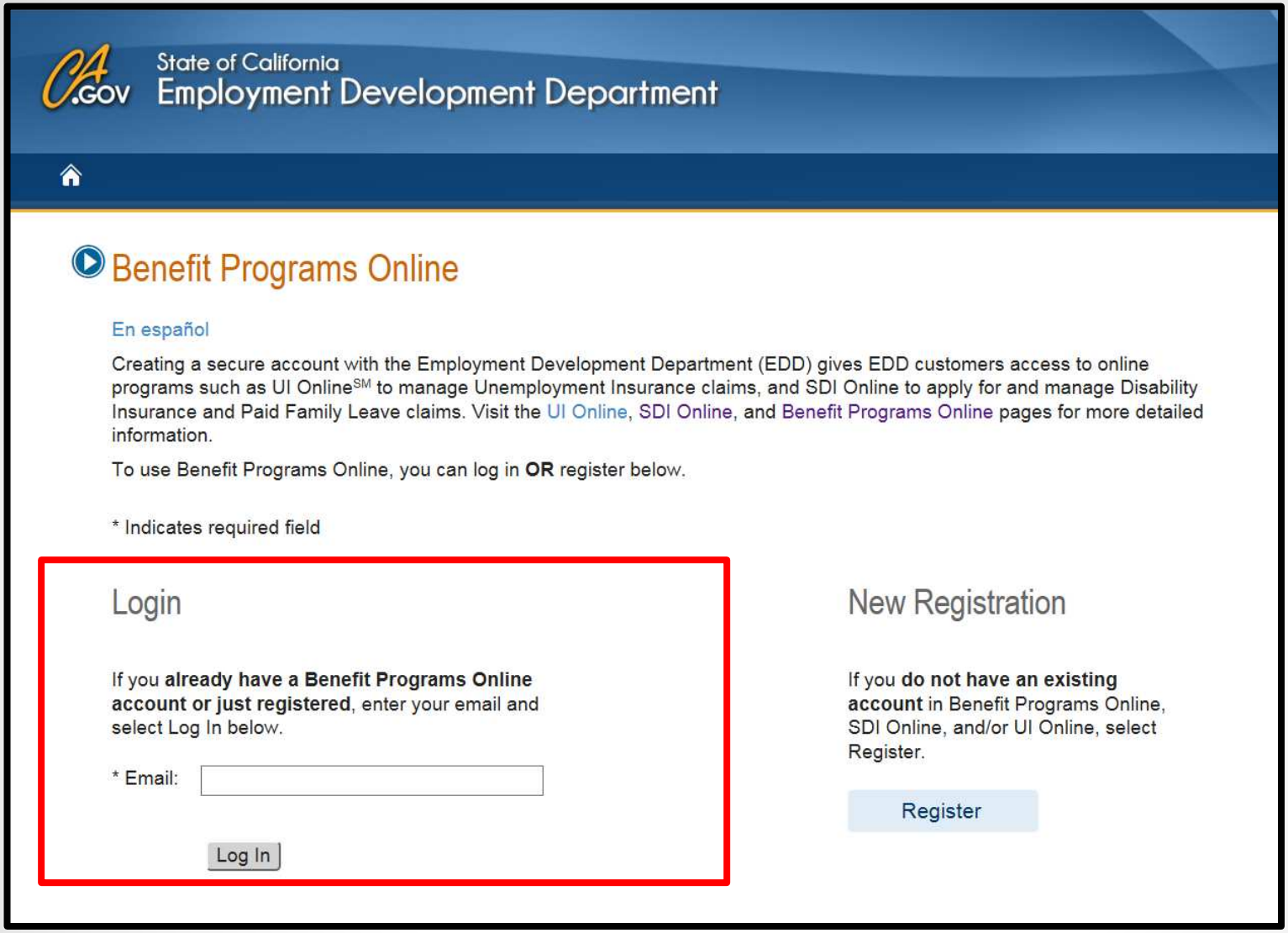
To register for Benefit Programs Online, visit: **edd.ca.gov/BPO**.

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.



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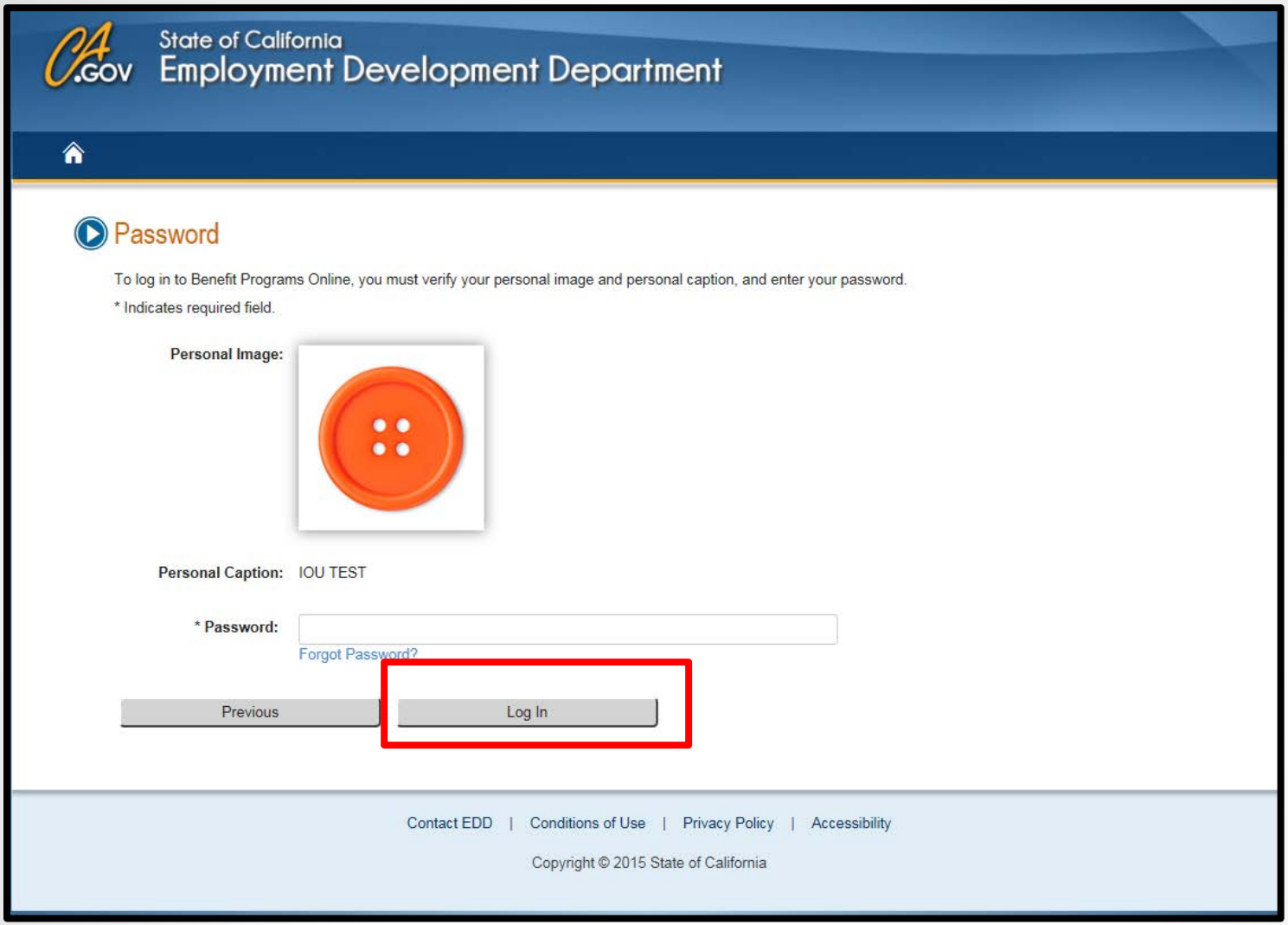

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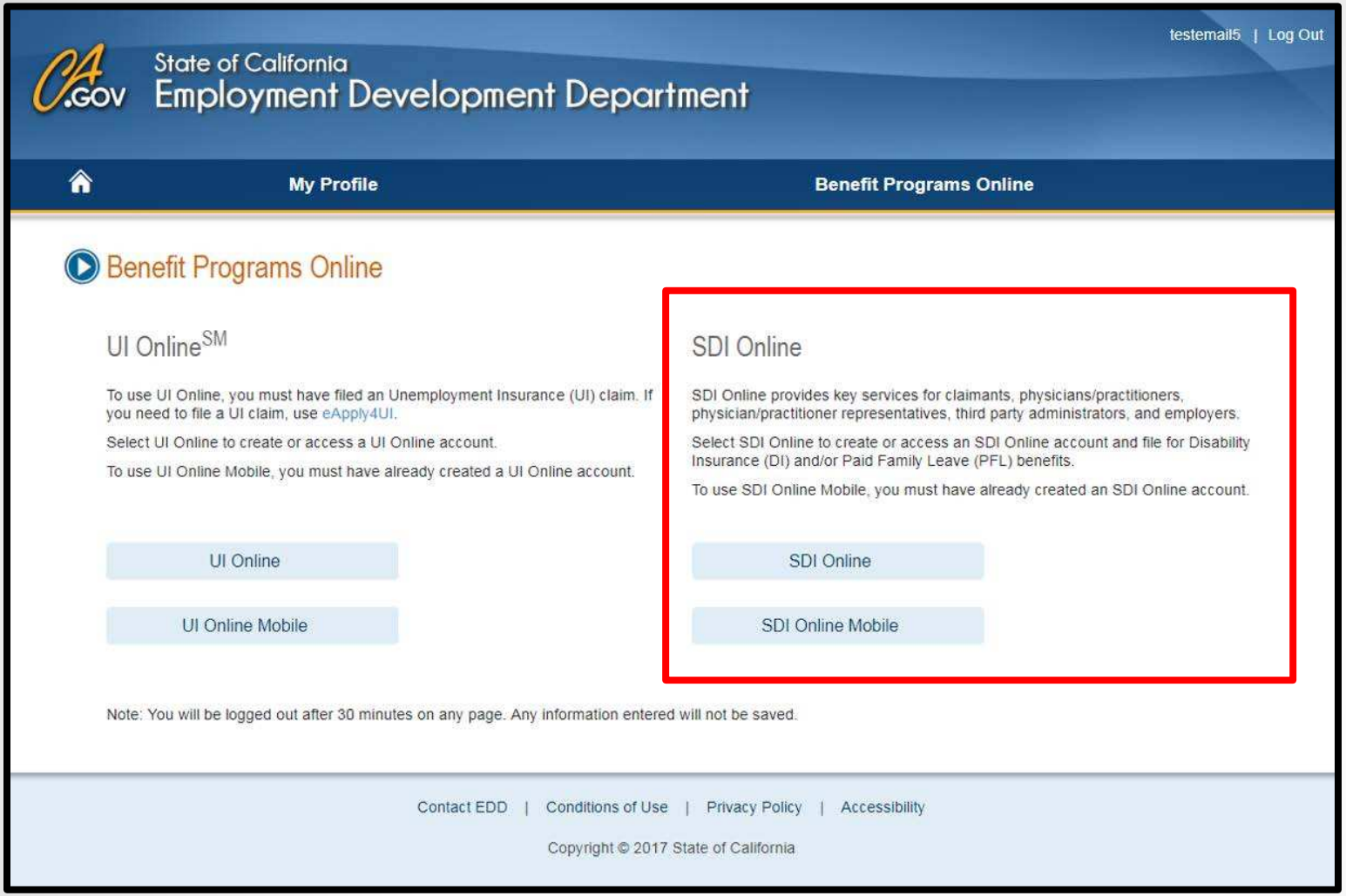
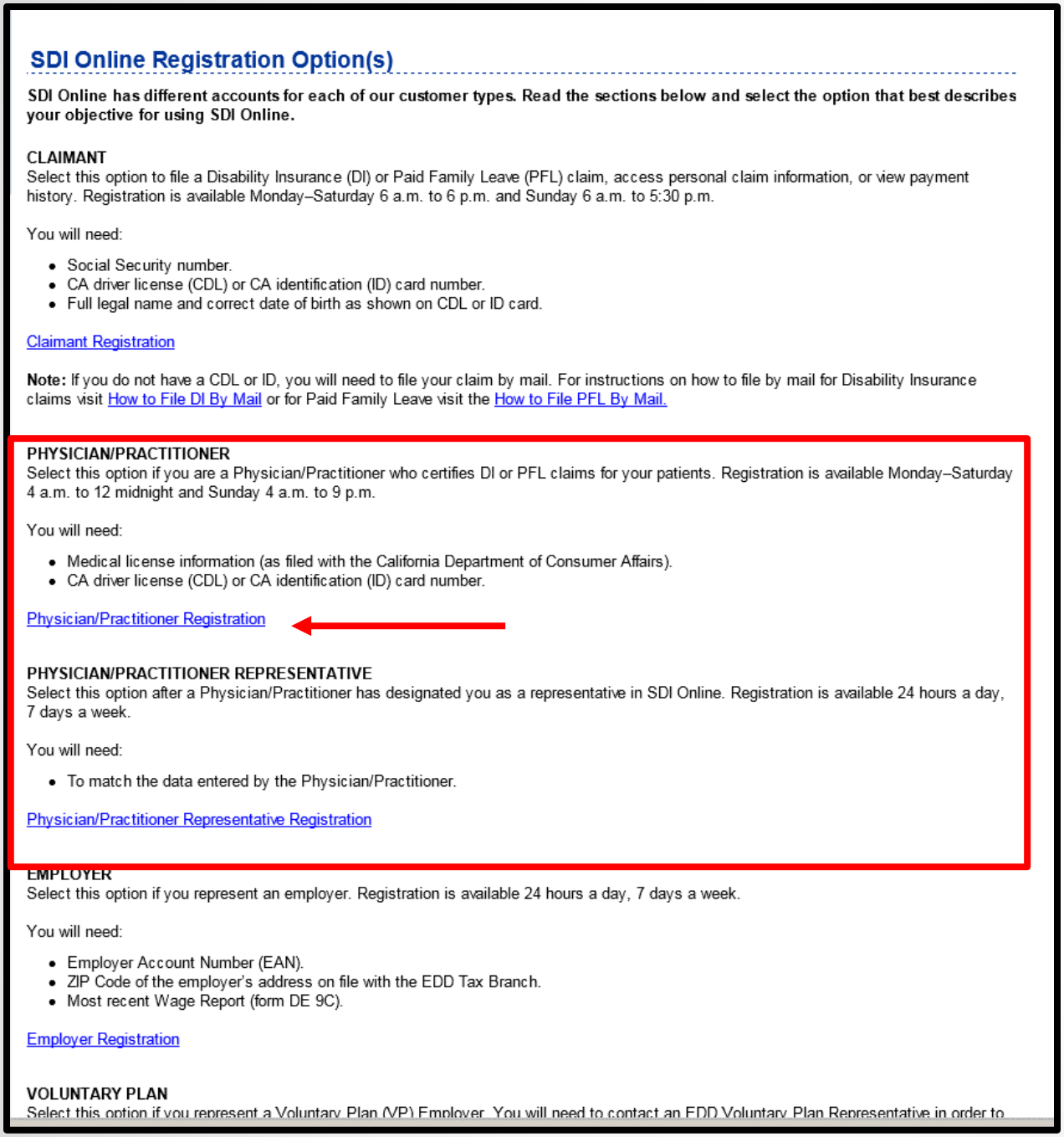


To log out of Benefit Programs Online from any page, select the **Log Out** link in the top right hand corner.

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
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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:

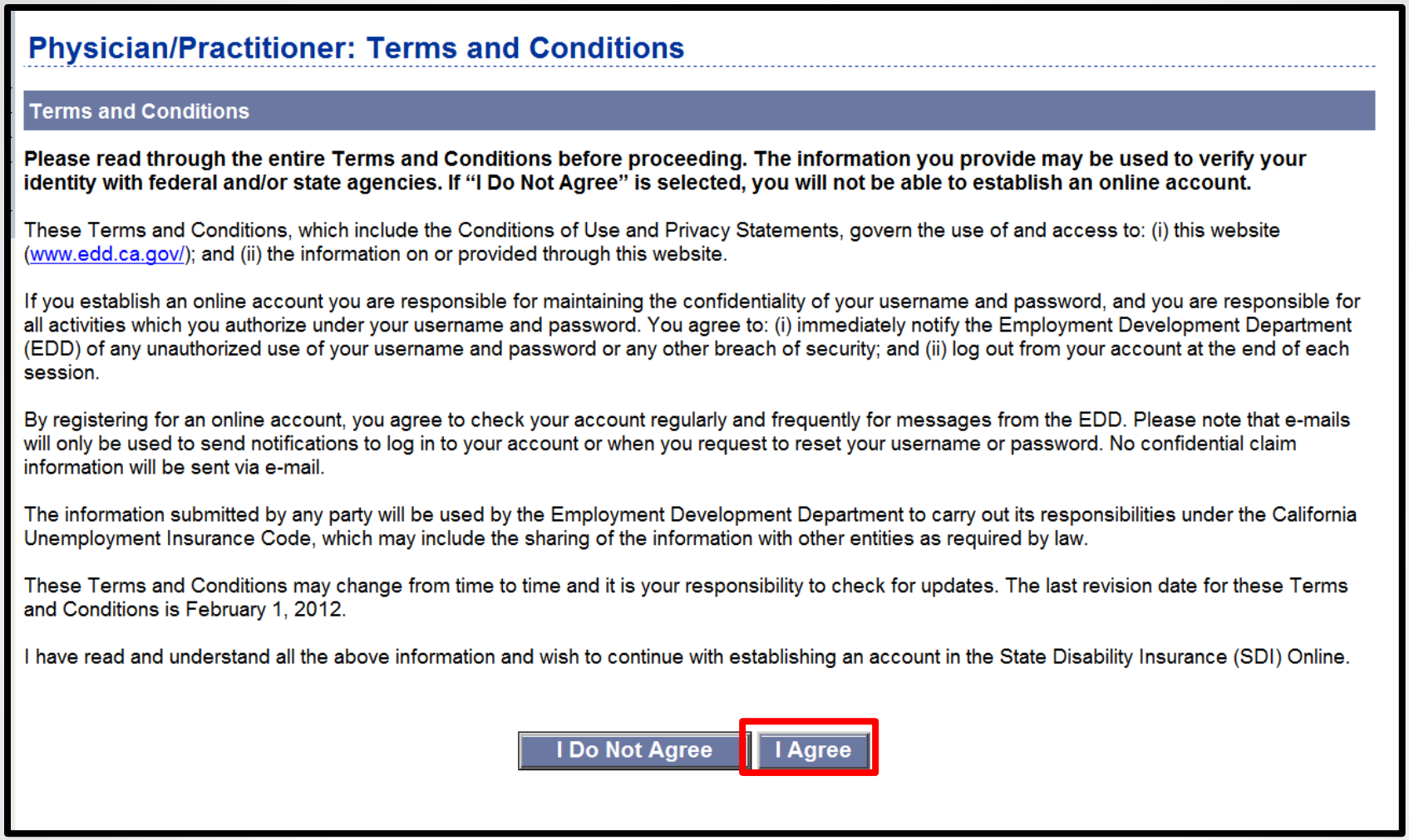
- Employer Account Number (EAN).
- ZIP Code of the employer's address on file with the EDD Tax Branch.
- Most recent Wage Report (form DE 9C).

Employer Registration

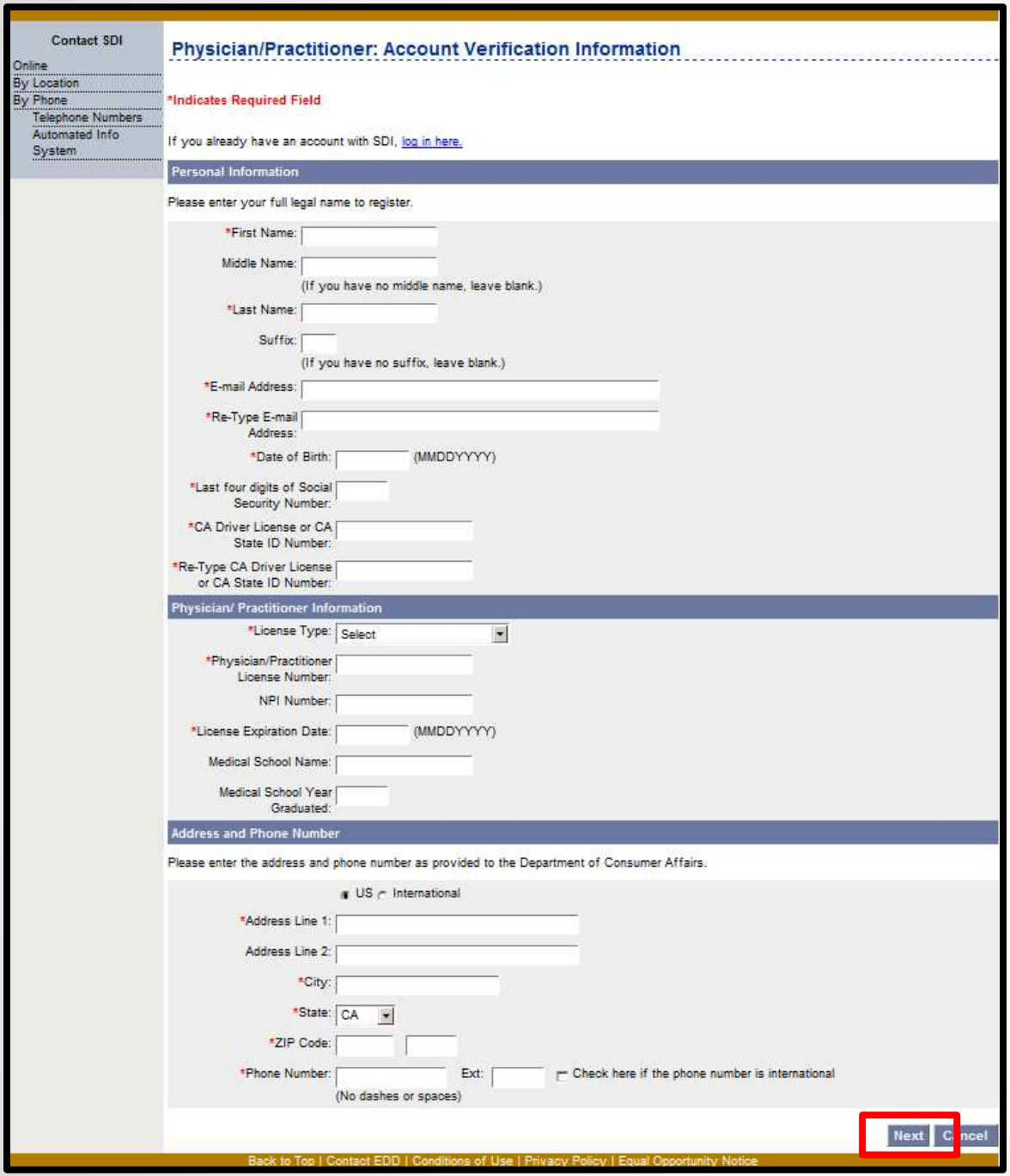
VOLUNTARY PLAN
Select this option if you represent a Voluntary Plan (VP) Employer. You will need to contact an EDD Voluntary Plan Representative in order to

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

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



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



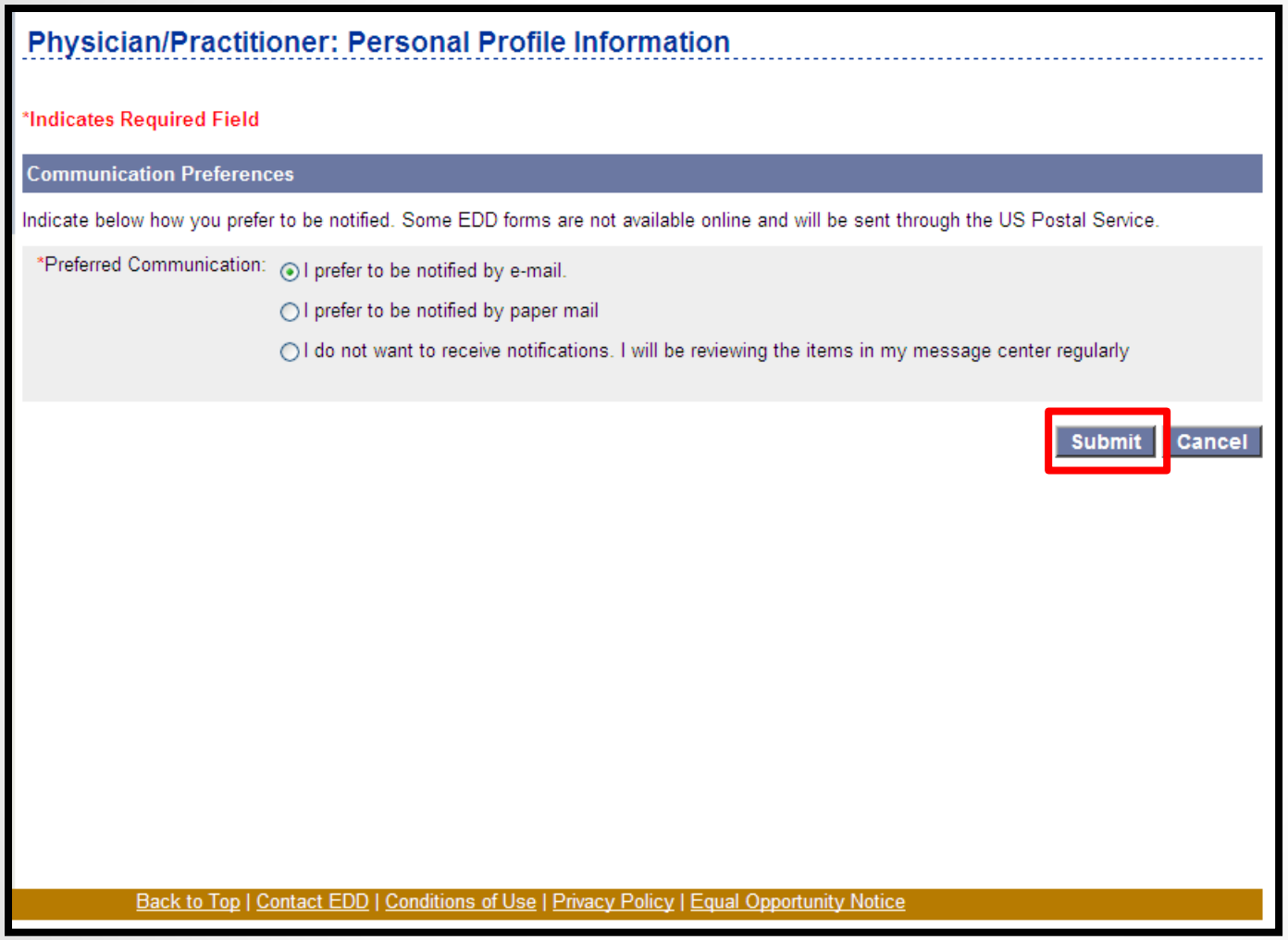
Complete the account verification information and select **Next**.

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

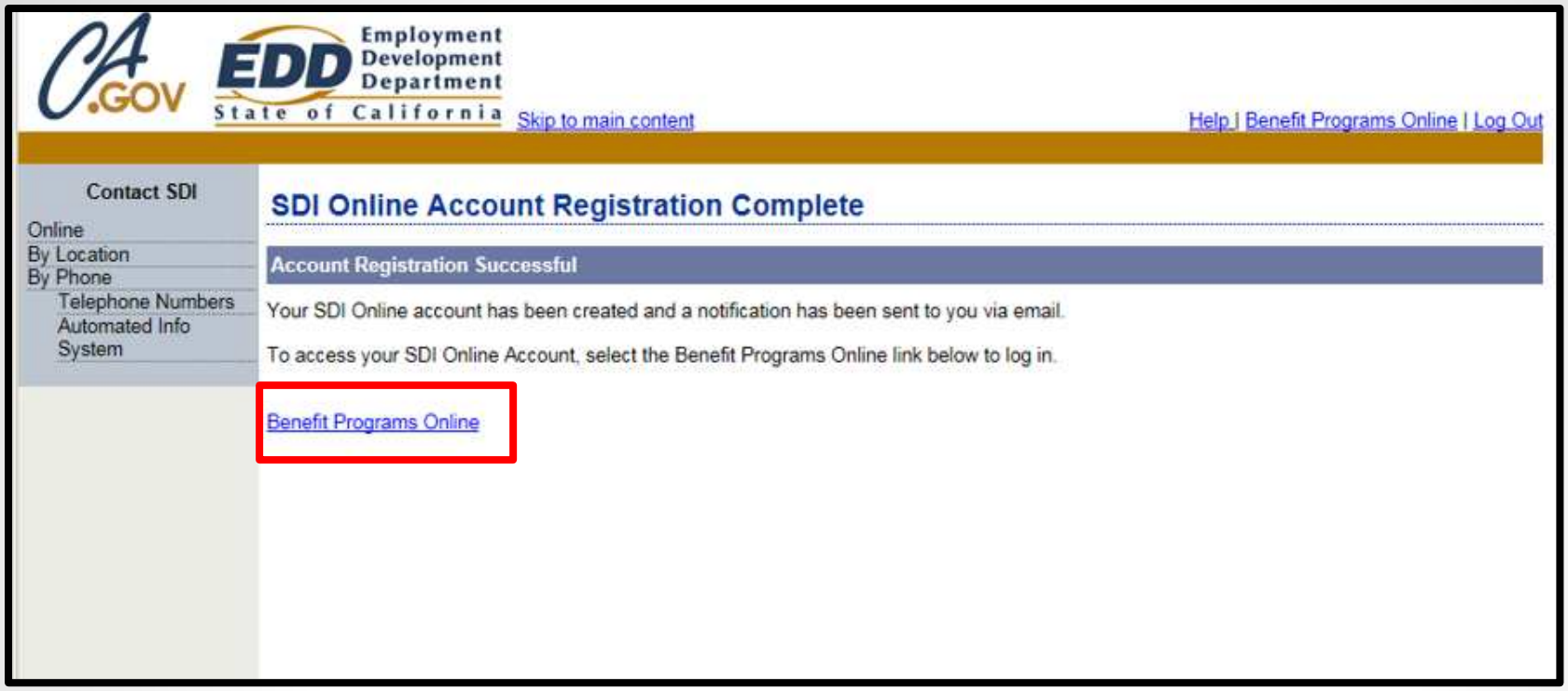
When creating an SDI Online account, remember to:

- 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.



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



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

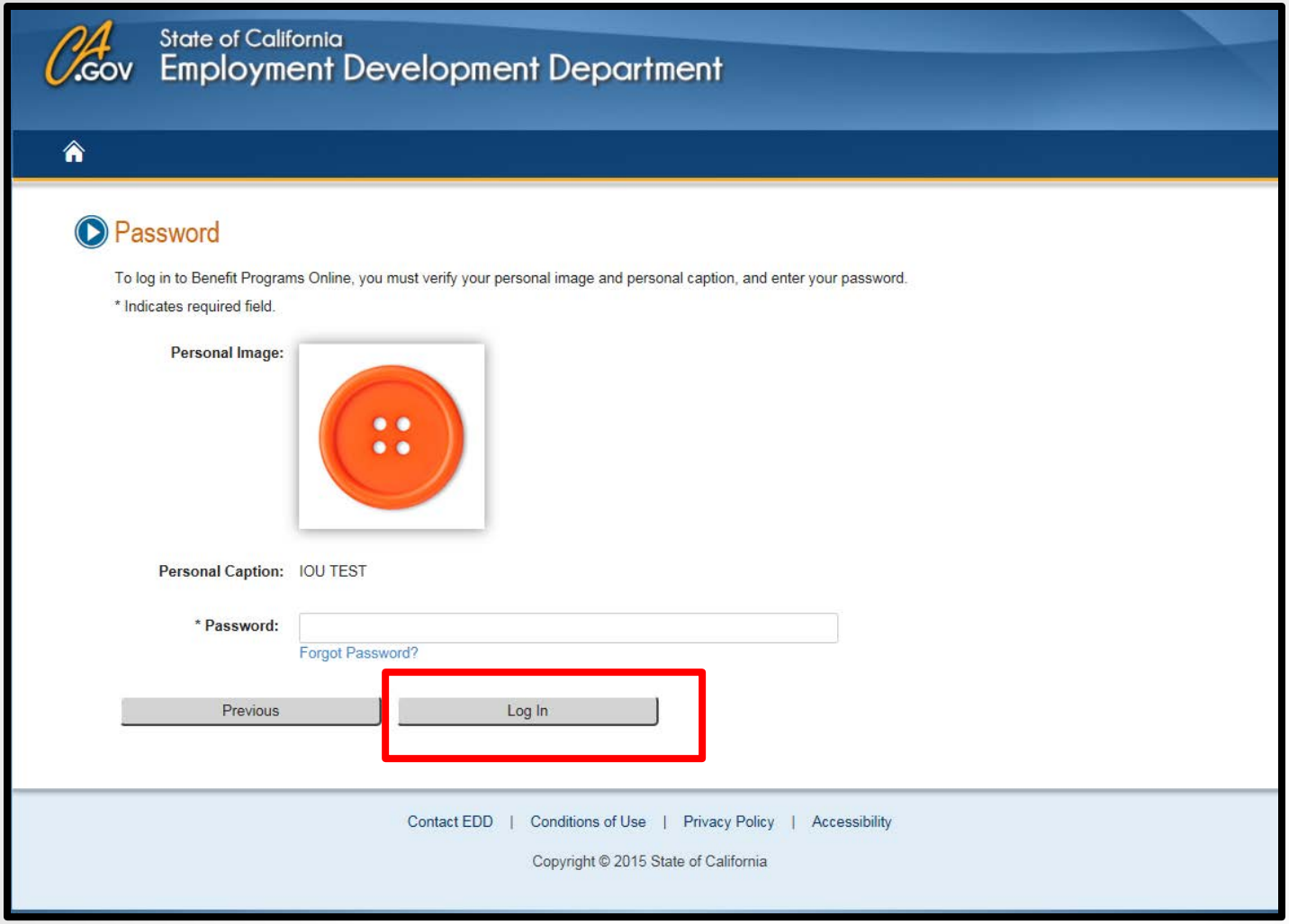
If you selected electronic communication, a notification will also be sent to you via email.

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

Access Your Physician/Practitioner Account

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.



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

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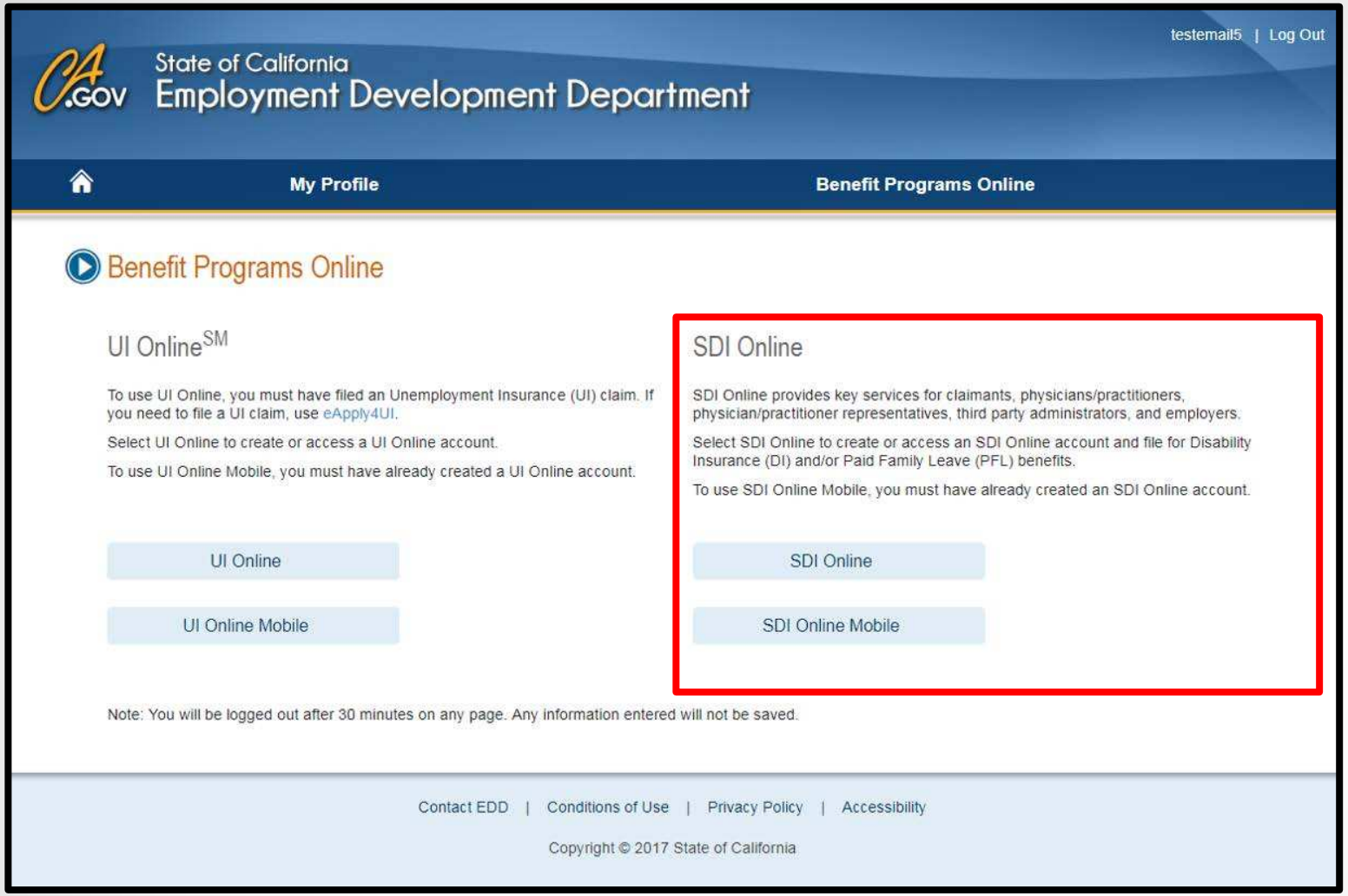


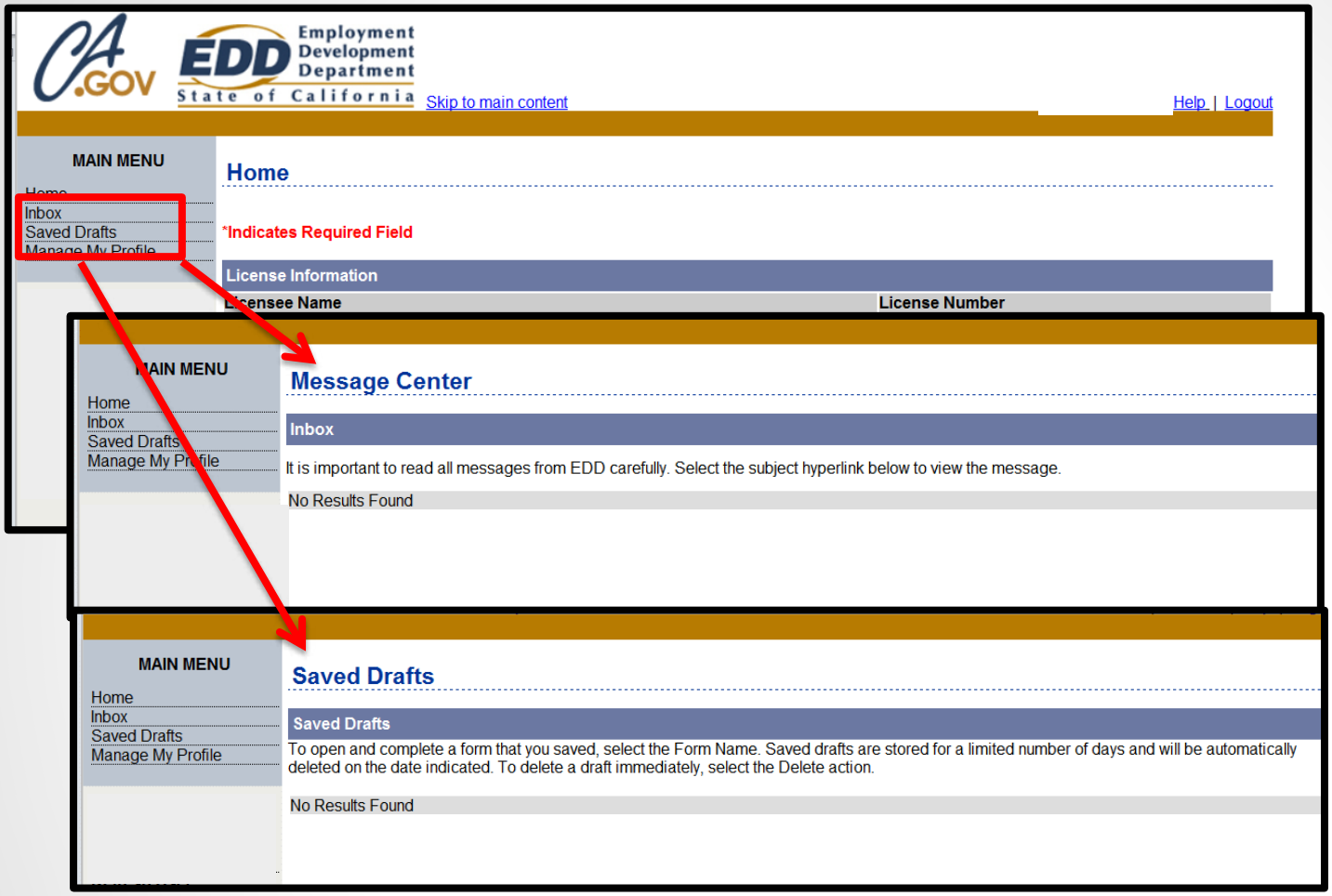
Select **SDI Online** or **SDI Online Mobile**.

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

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.



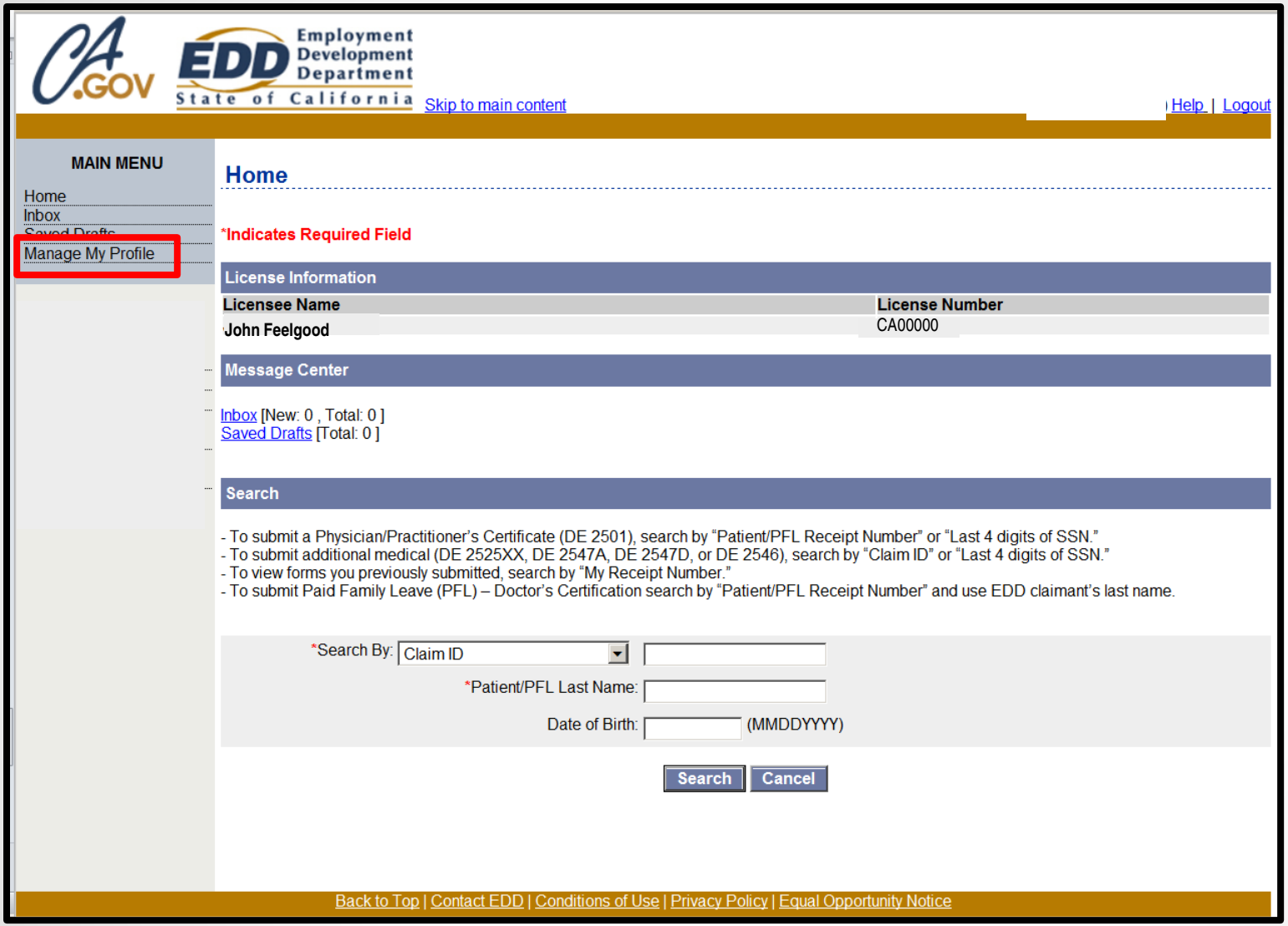
The **Main Menu** appears on most screens and has additional options.

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

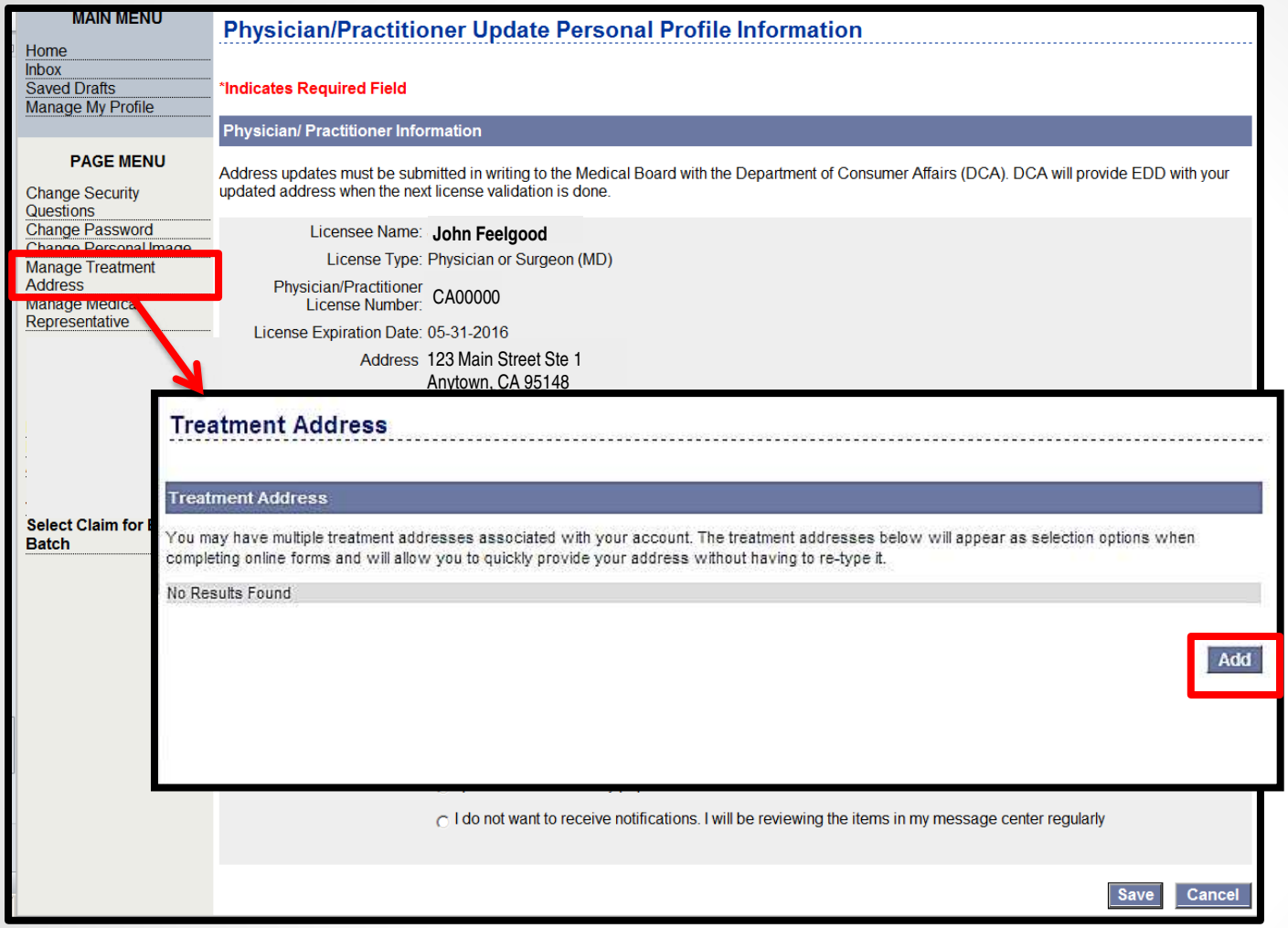
Saved Drafts: View previously saved drafts of forms that were started, but not completed or submitted.

Note: Saved Drafts are deleted after 30 days.

Add a Treatment Address

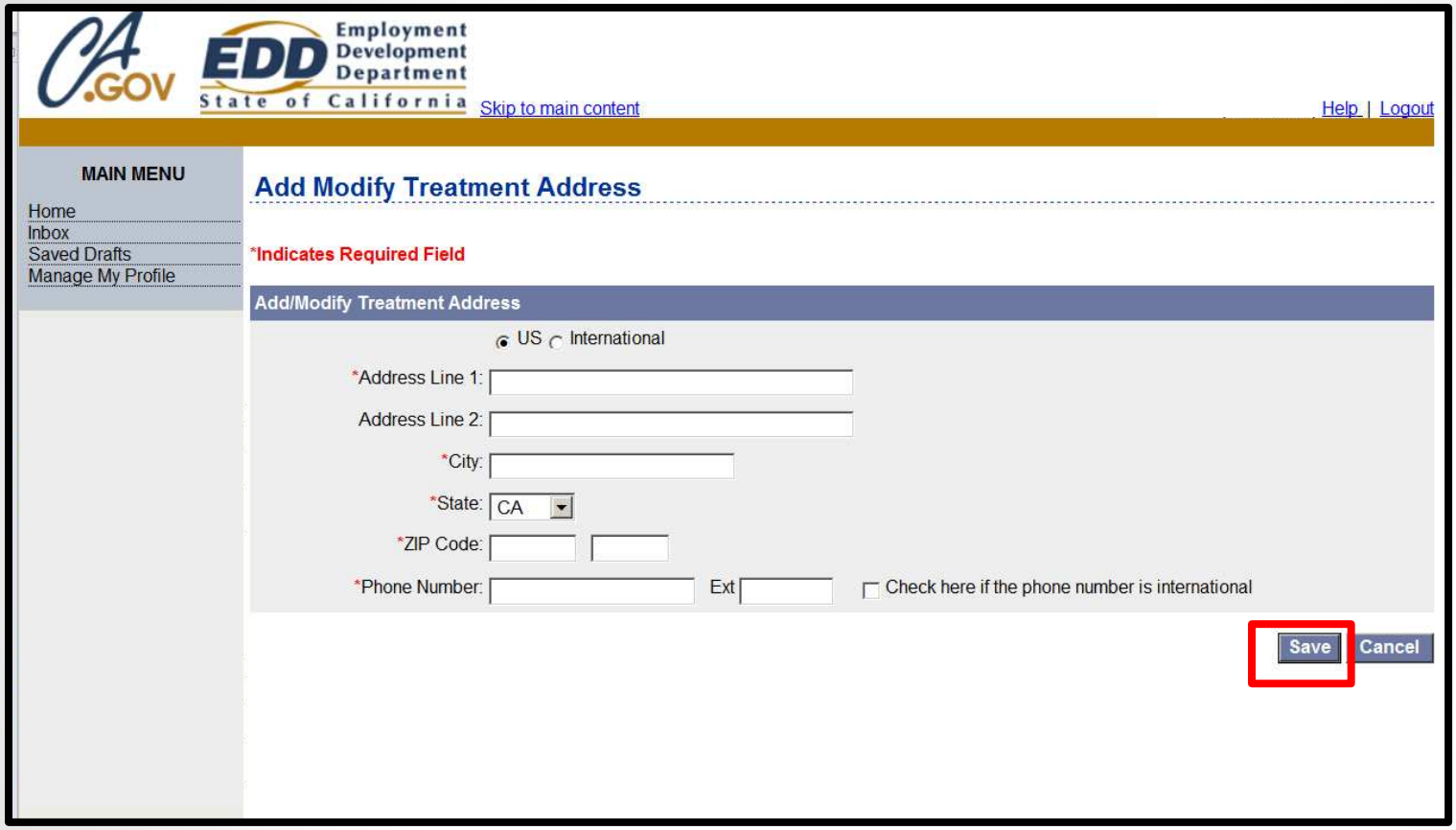


To add a treatment address, select **Manage My Profile** under the **Main Menu** on the **Home** page.



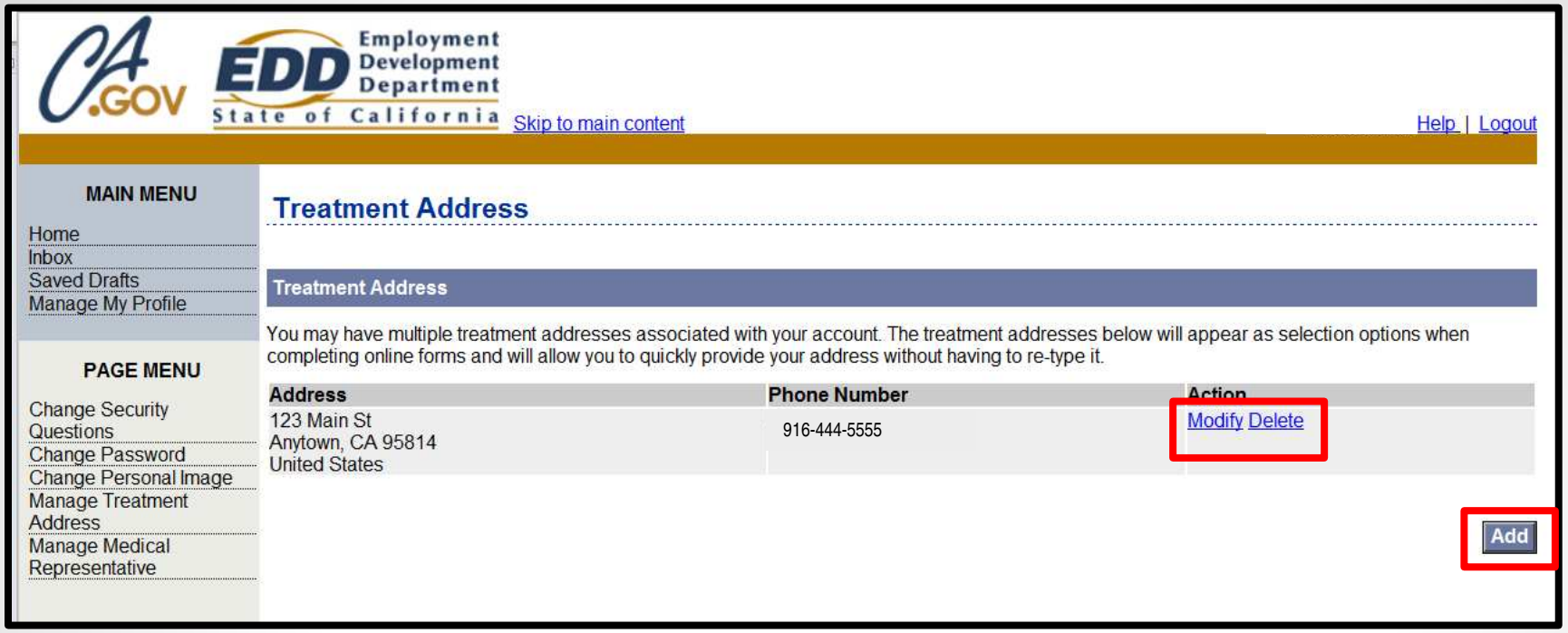
You will be directed to the **Physician/Practitioner Update Personal Profile Information** page.

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



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.

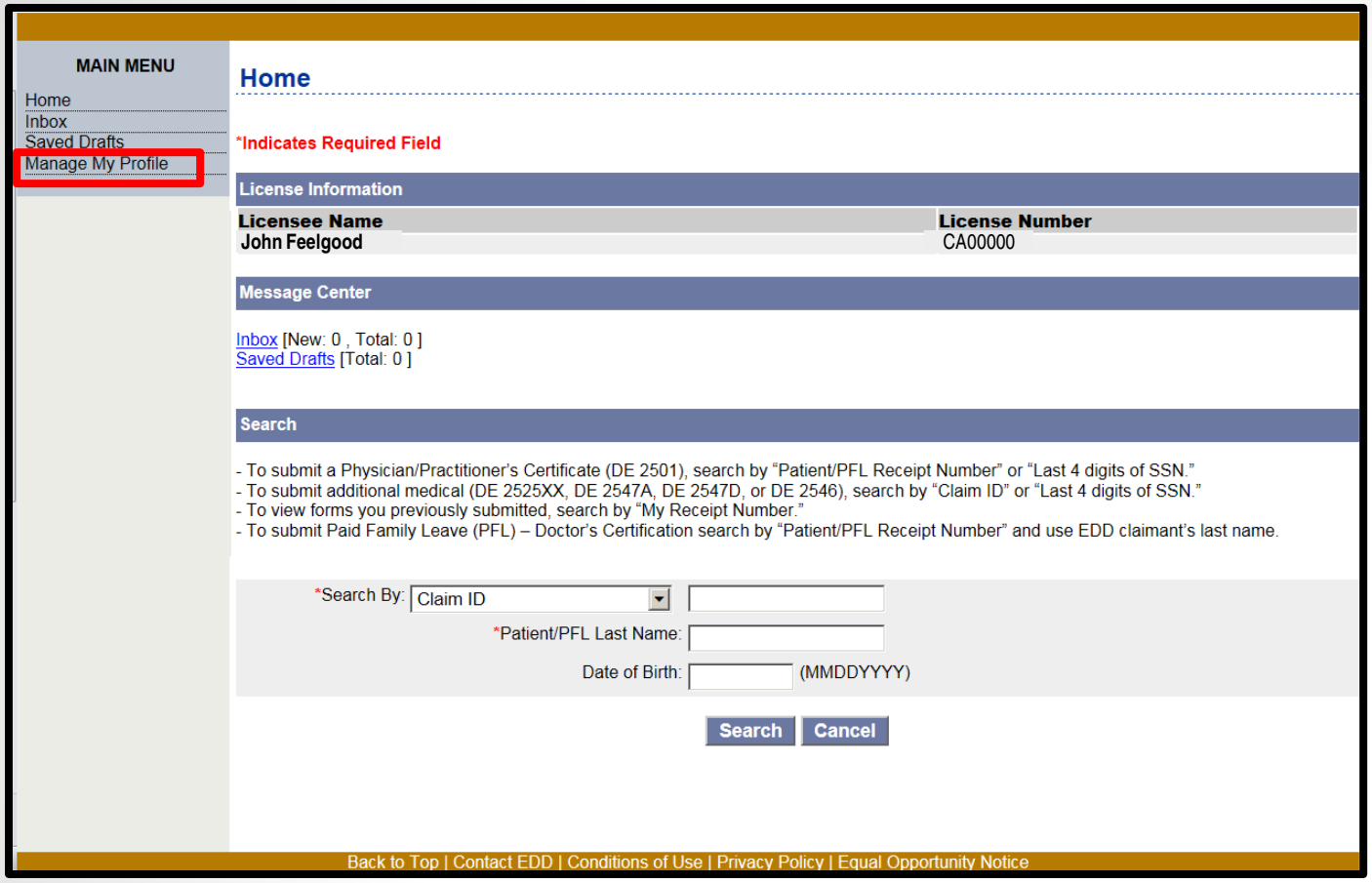


Treatment addresses added are displayed on this page.

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

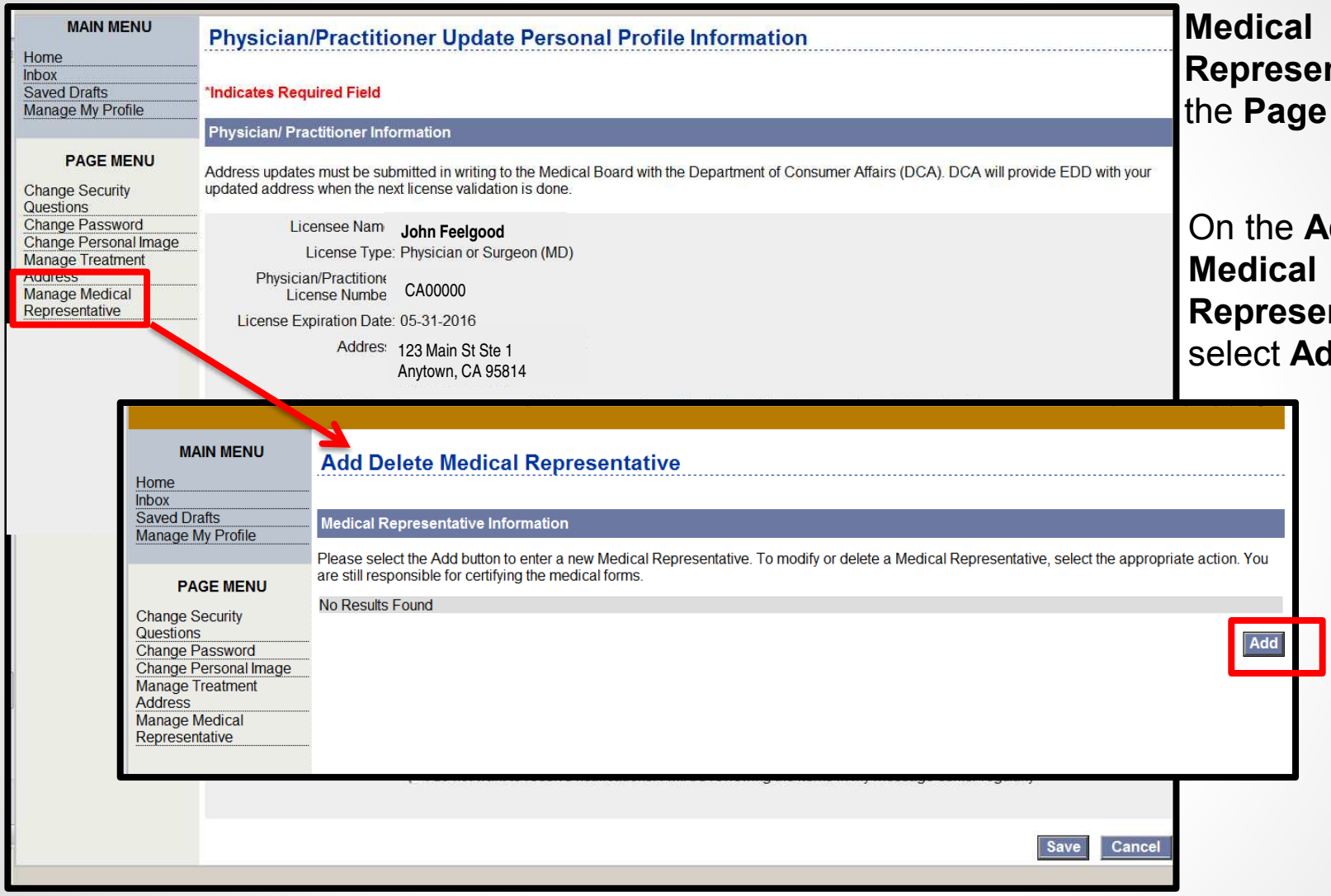
To add additional treatment addresses, select **Add**.

Assign a Physician/Practitioner Representative



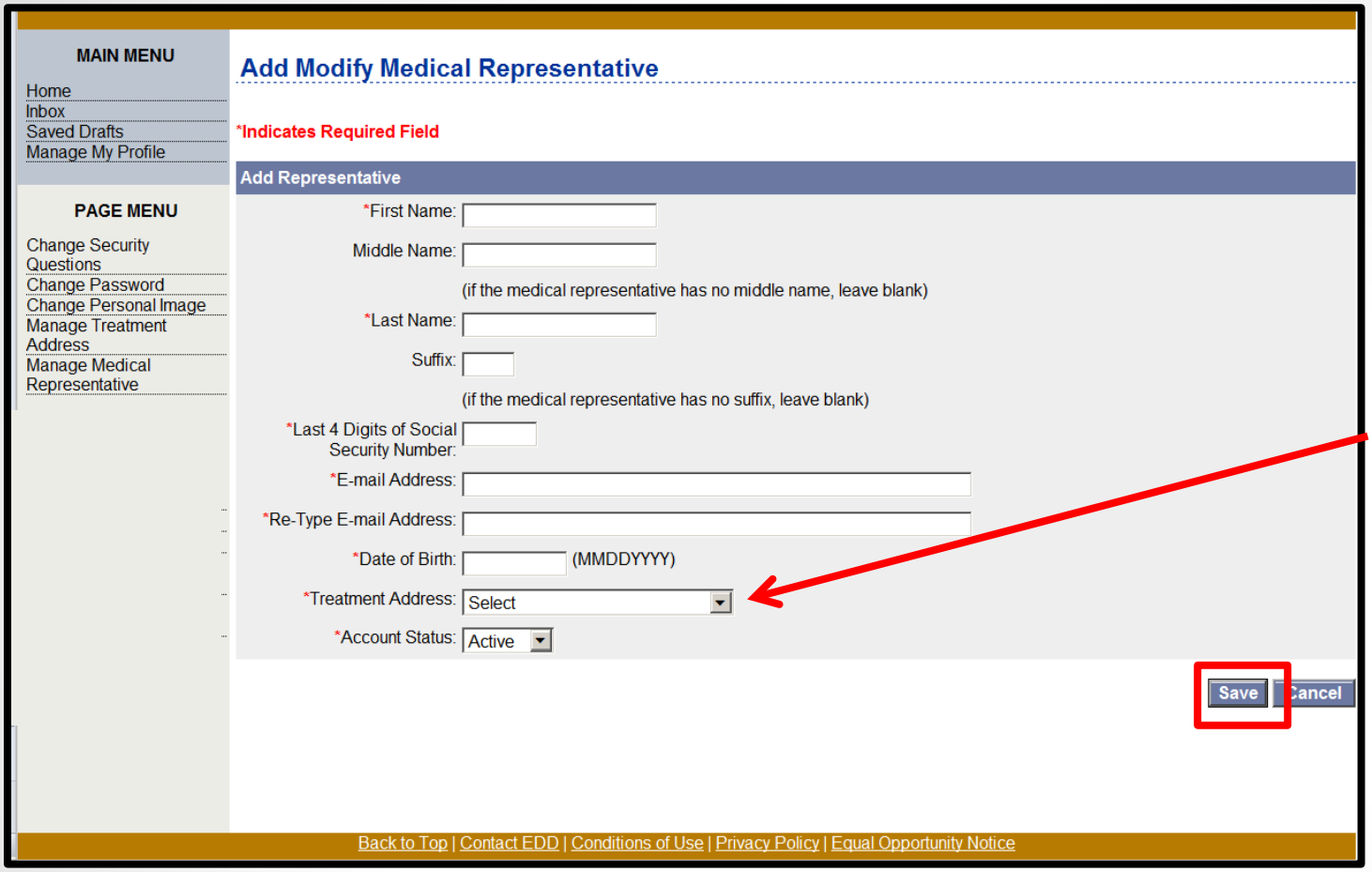
Physician/practitioner representatives can complete and submit forms on behalf of the registered physician/practitioner once they have been added to the account.

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

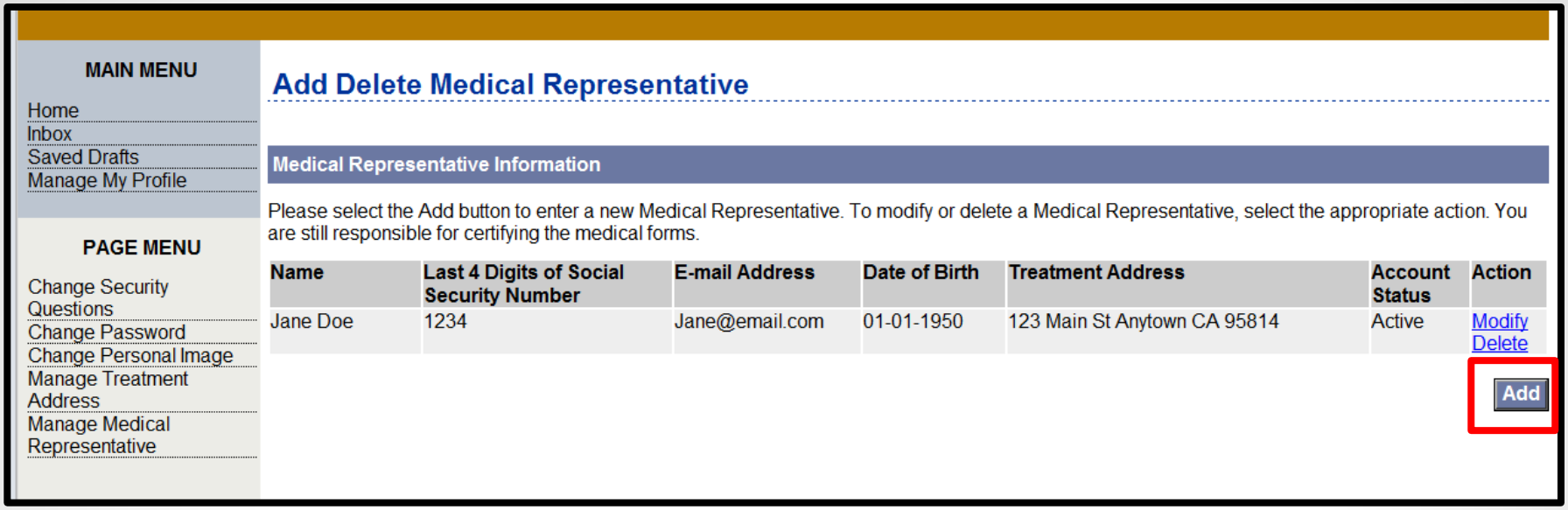


Select **Manage Medical Representative** from the **Page** Menu.

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



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



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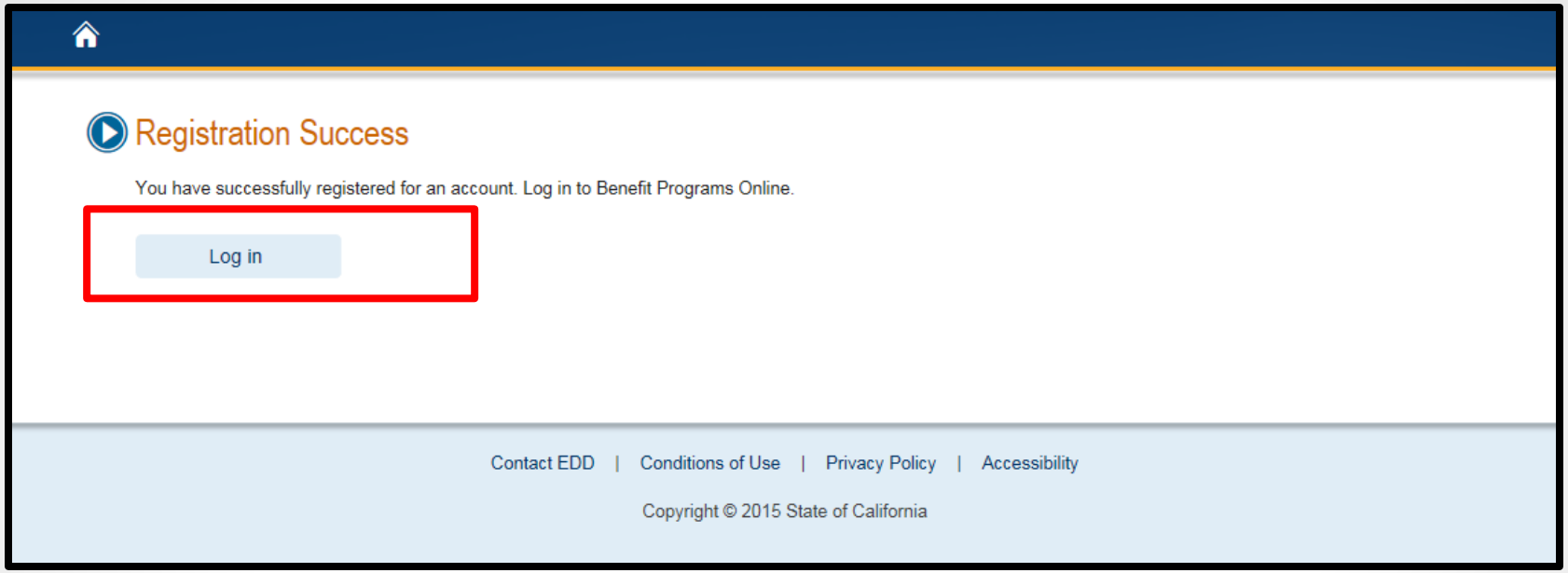
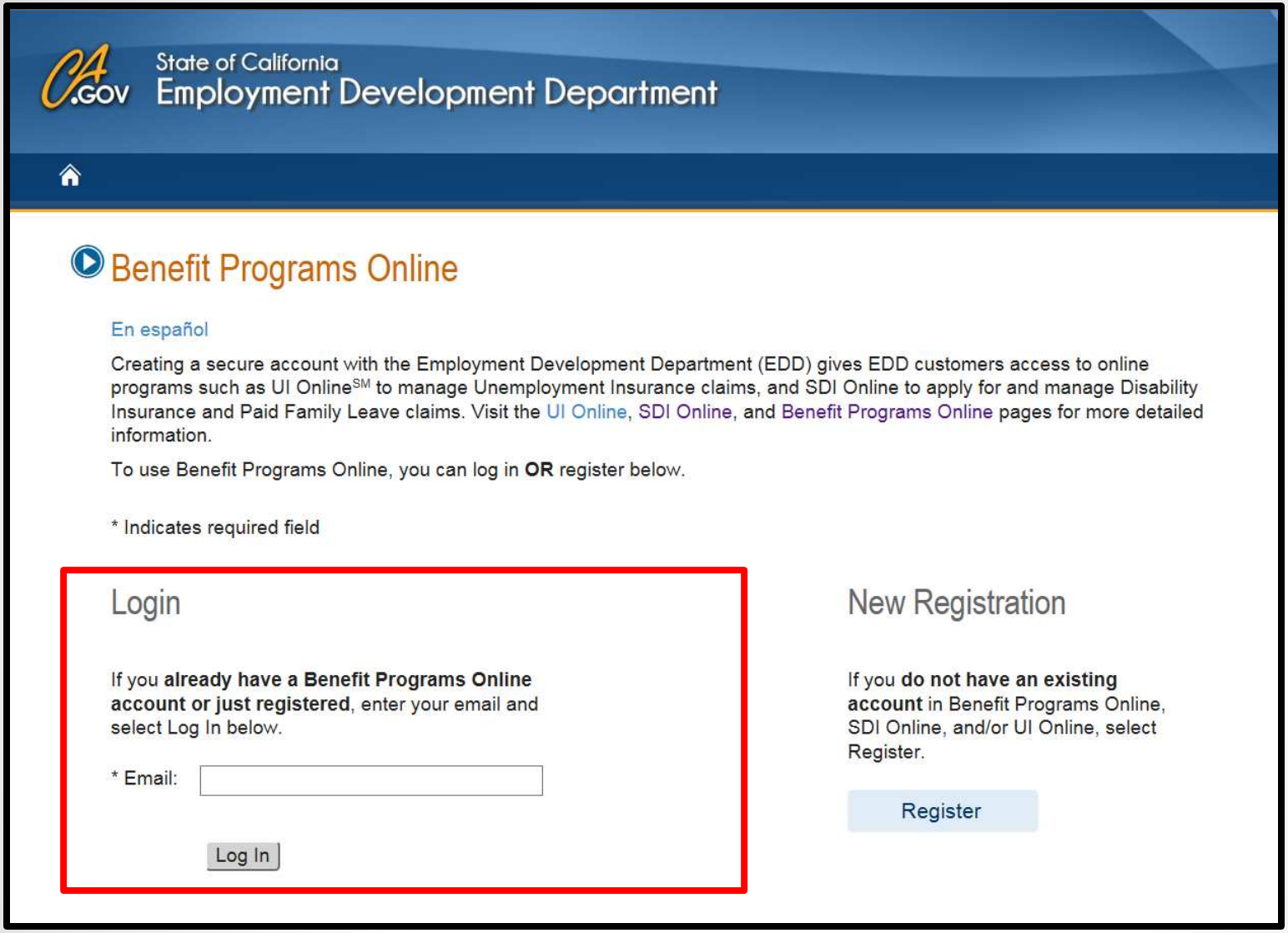
SDI Online Account Registration for Physician/Practitioner Representatives



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.



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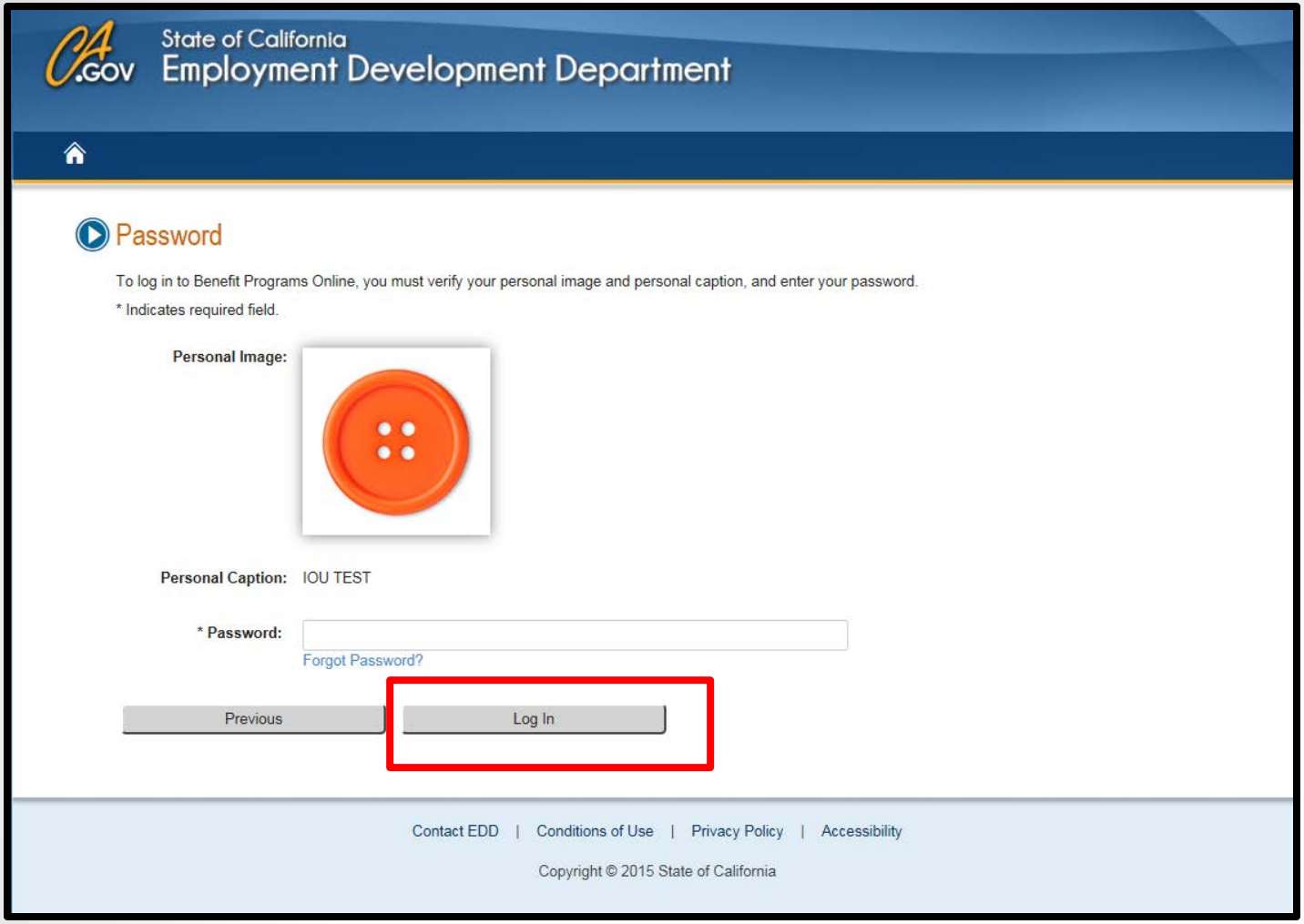

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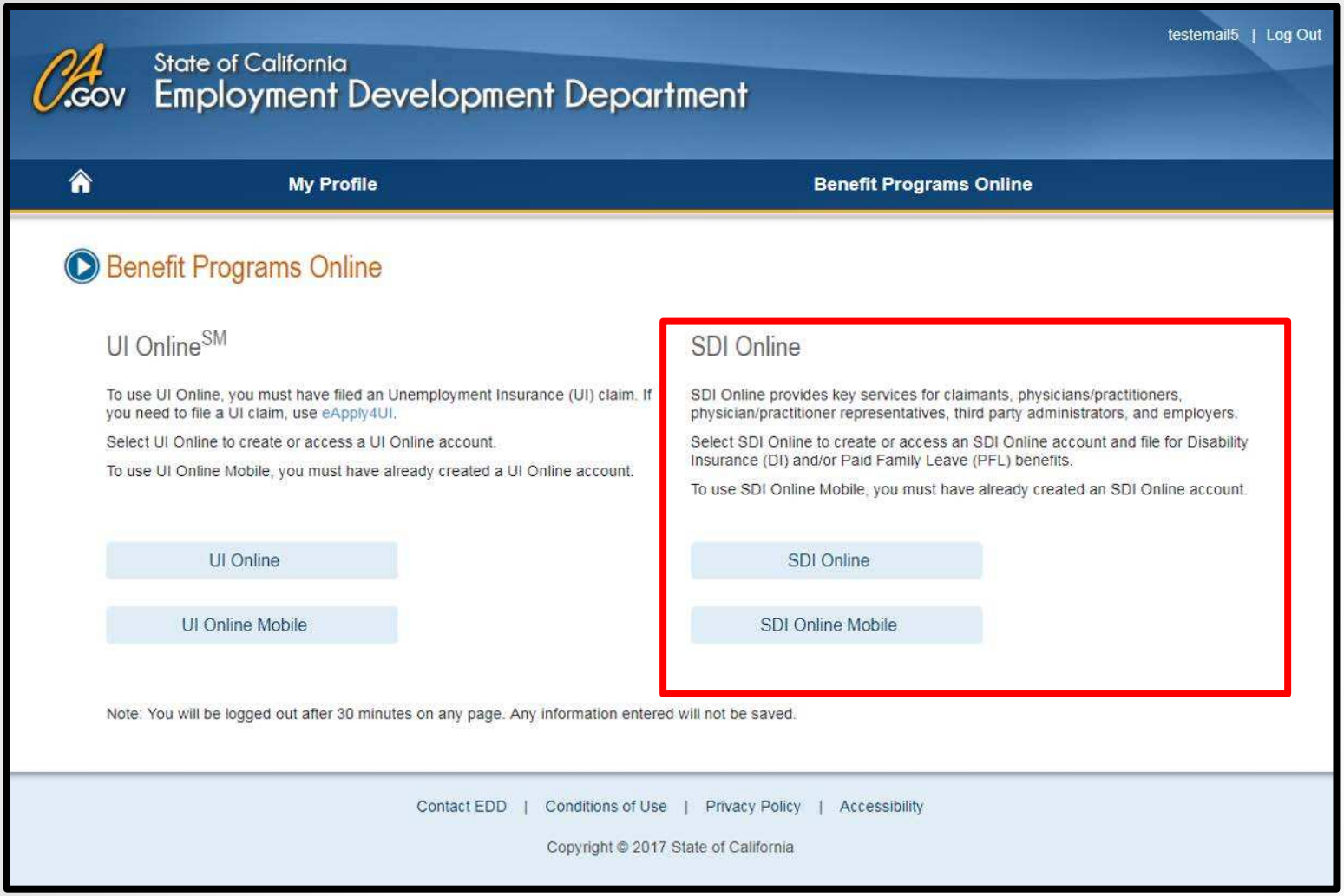

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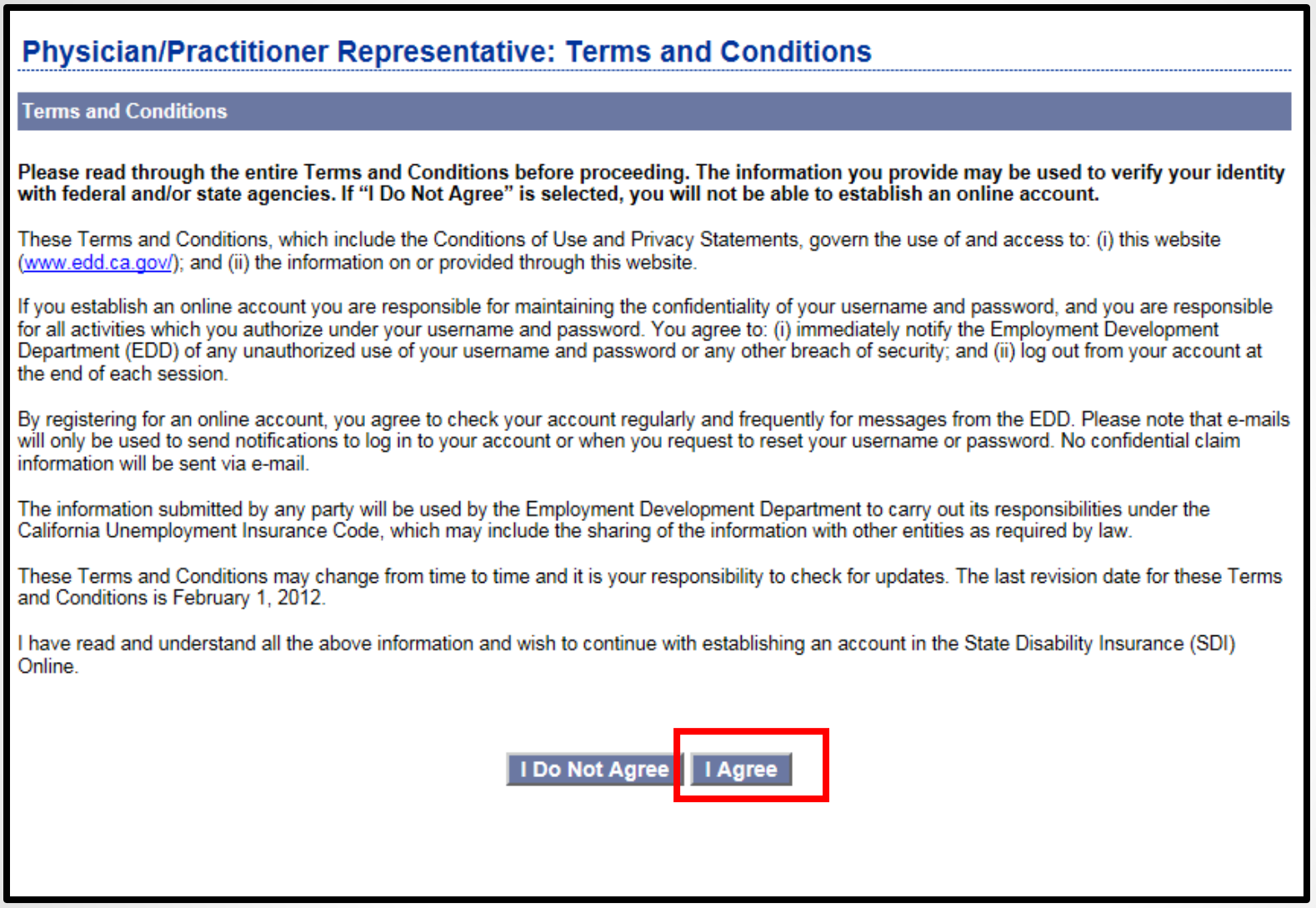
Select the link for **Physician/practitioner Representative Registration**.



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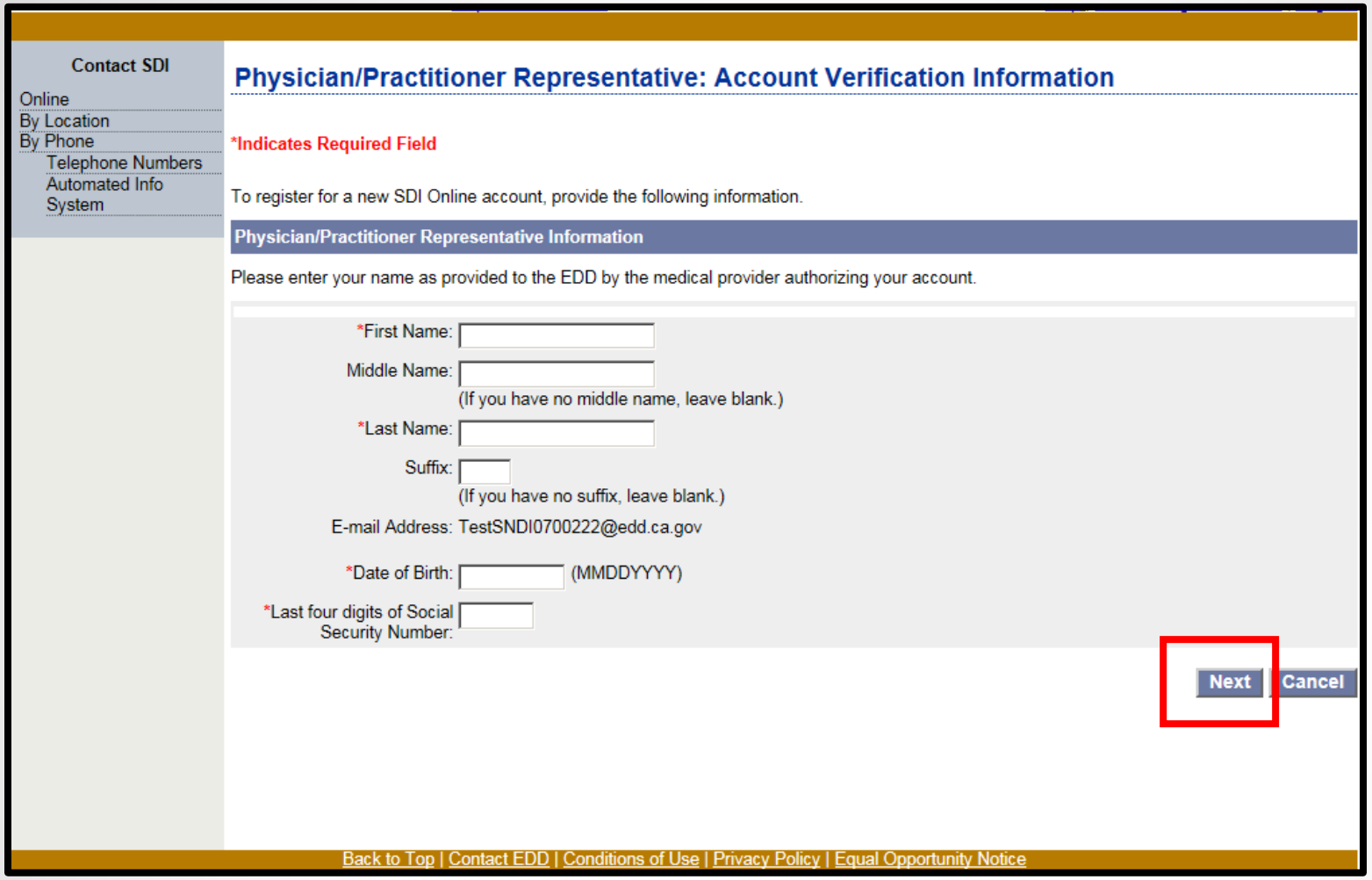
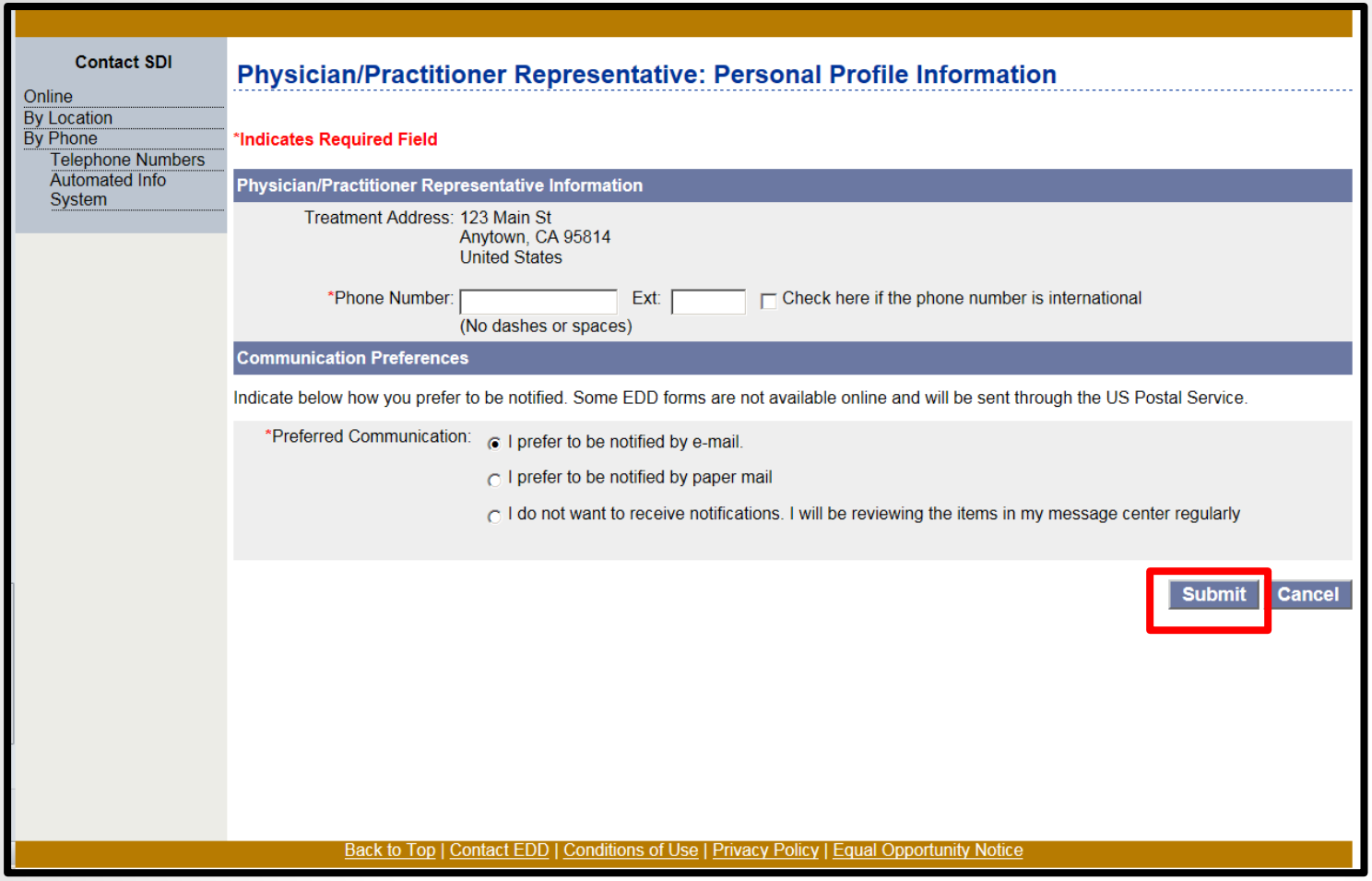
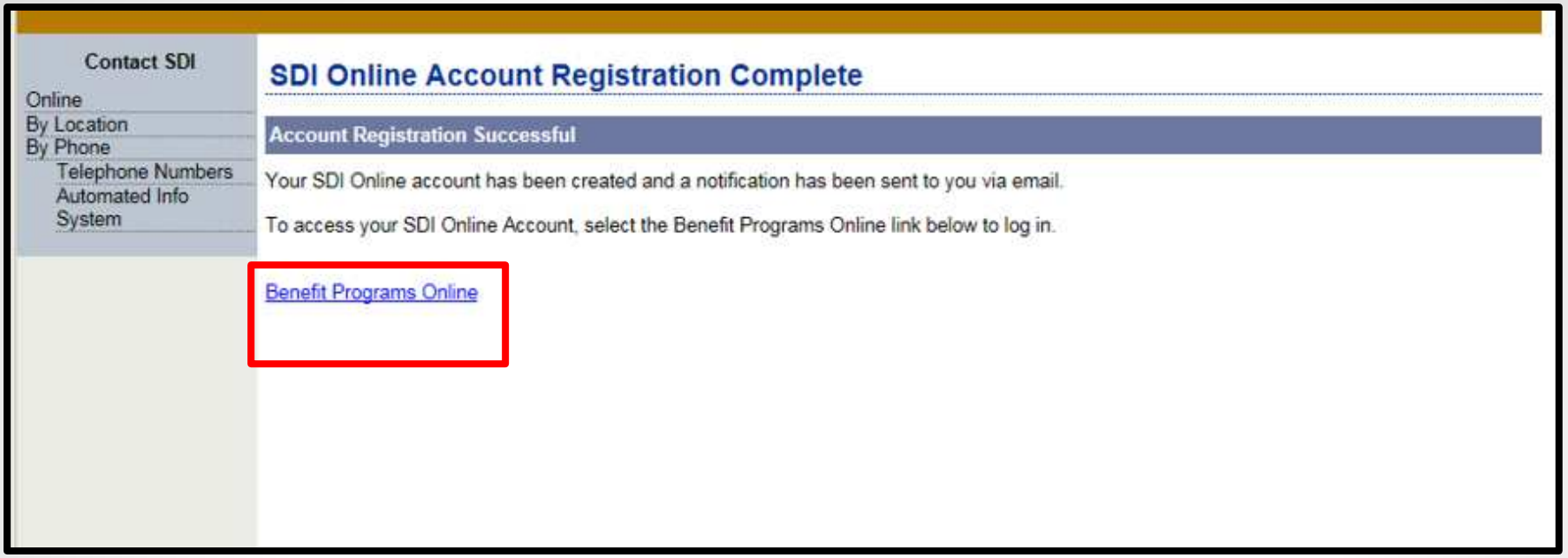


Complete the physician/practitioner representative information section. Be sure to enter your name exactly as provided to the EDD by the physician/practitioner authorizing your account, then select **Next**.



Verify the treatment address, enter the phone number, and select your preferred method of communication, then select **Submit.**

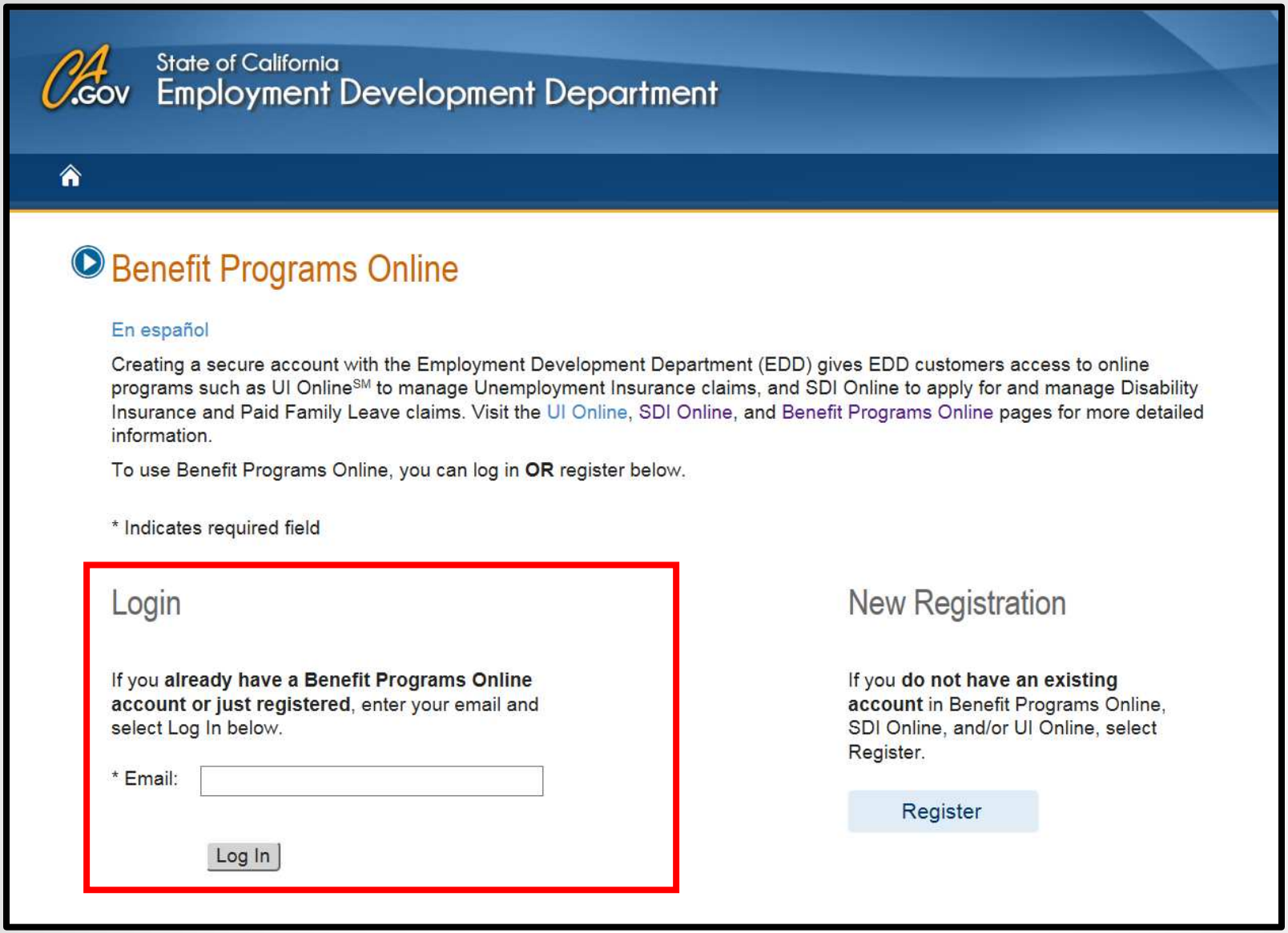
Note: The physician/practitioner can change the fields that a physician/practitioner representative cannot.



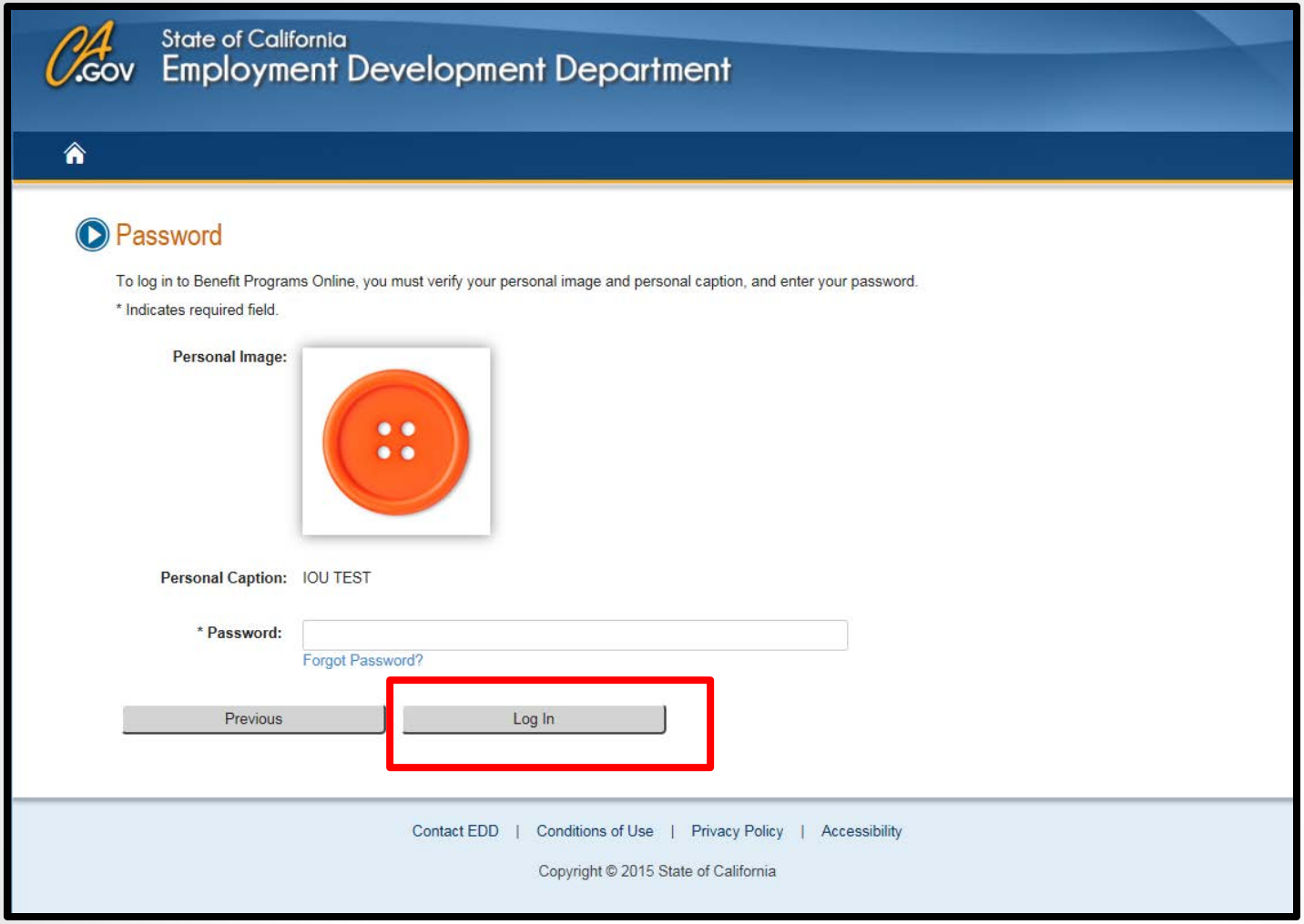
A letter will be mailed to the physician's/practitioner's address to confirm this account has been created.

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.



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



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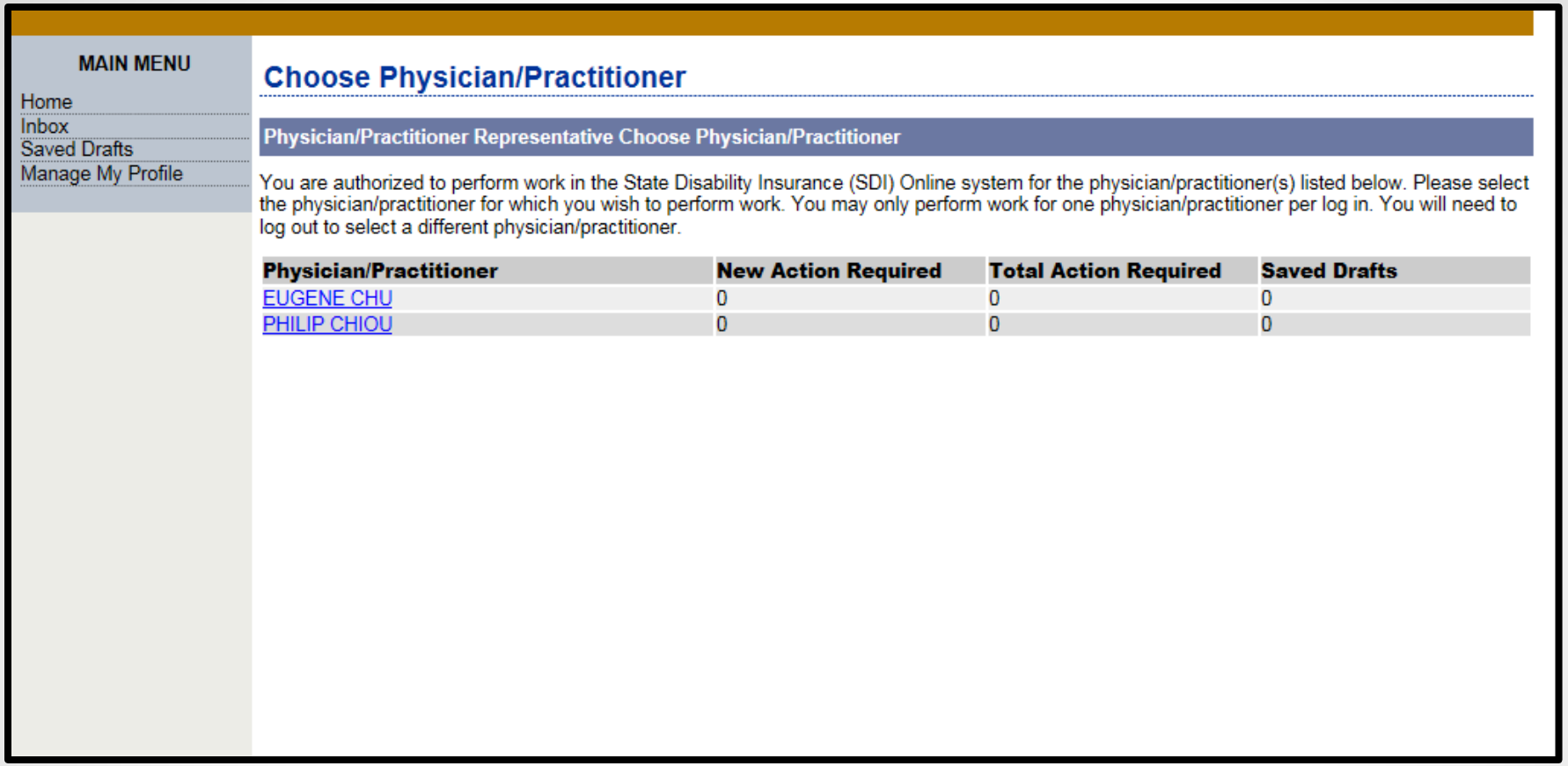
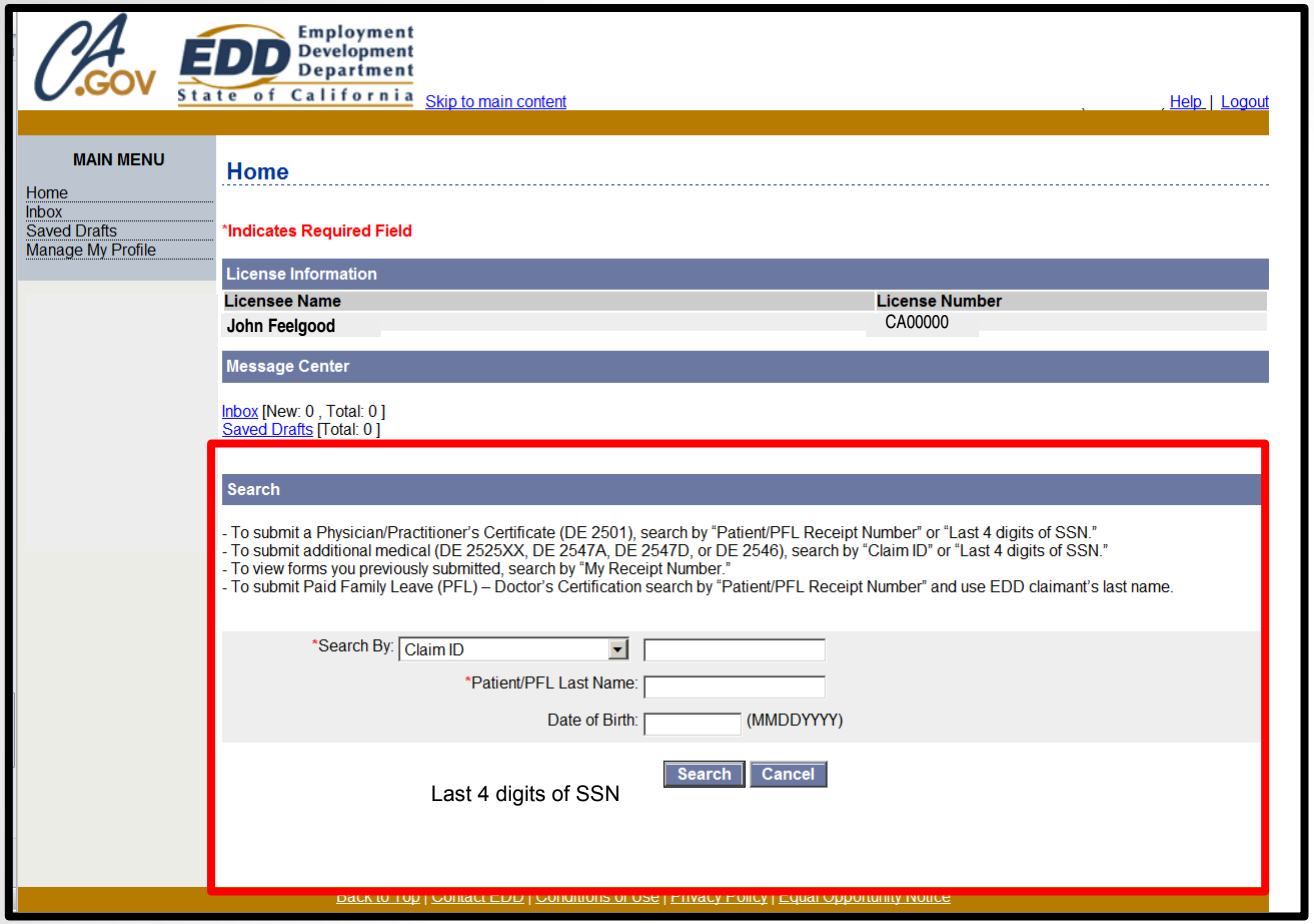


You may now select the physician/practitioner account you wish to work on.

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



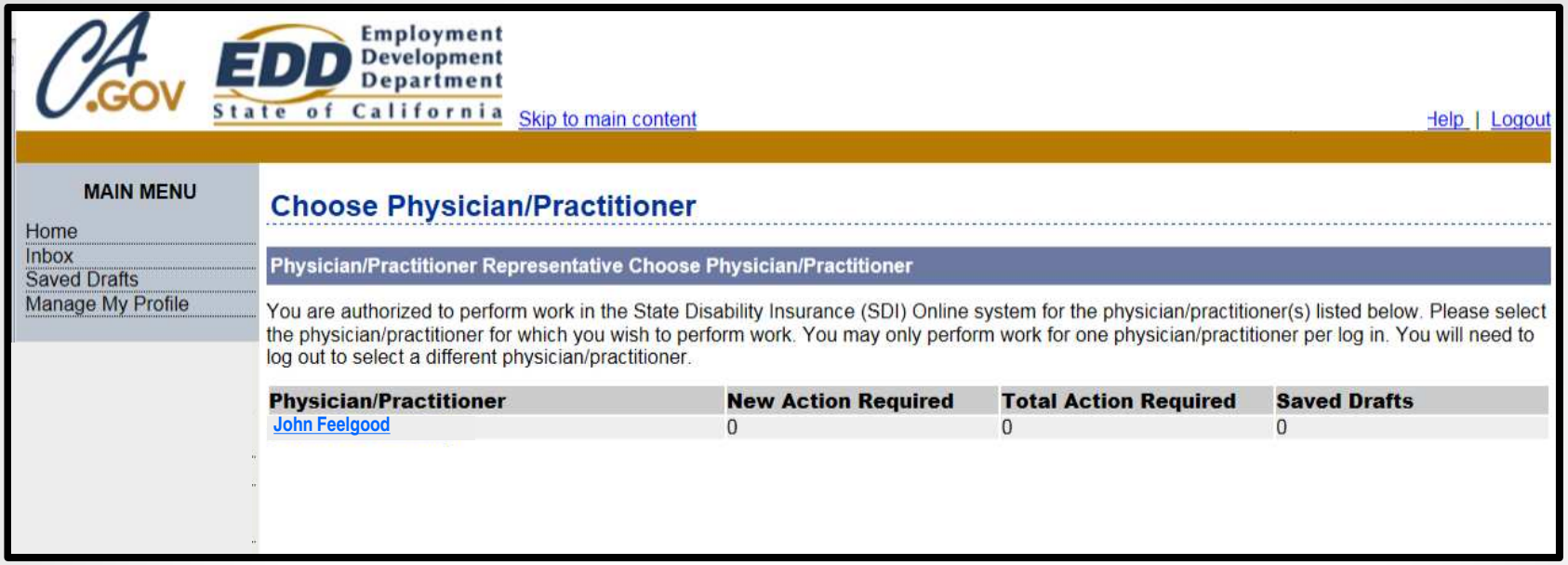
Physicians/Practitioners

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.

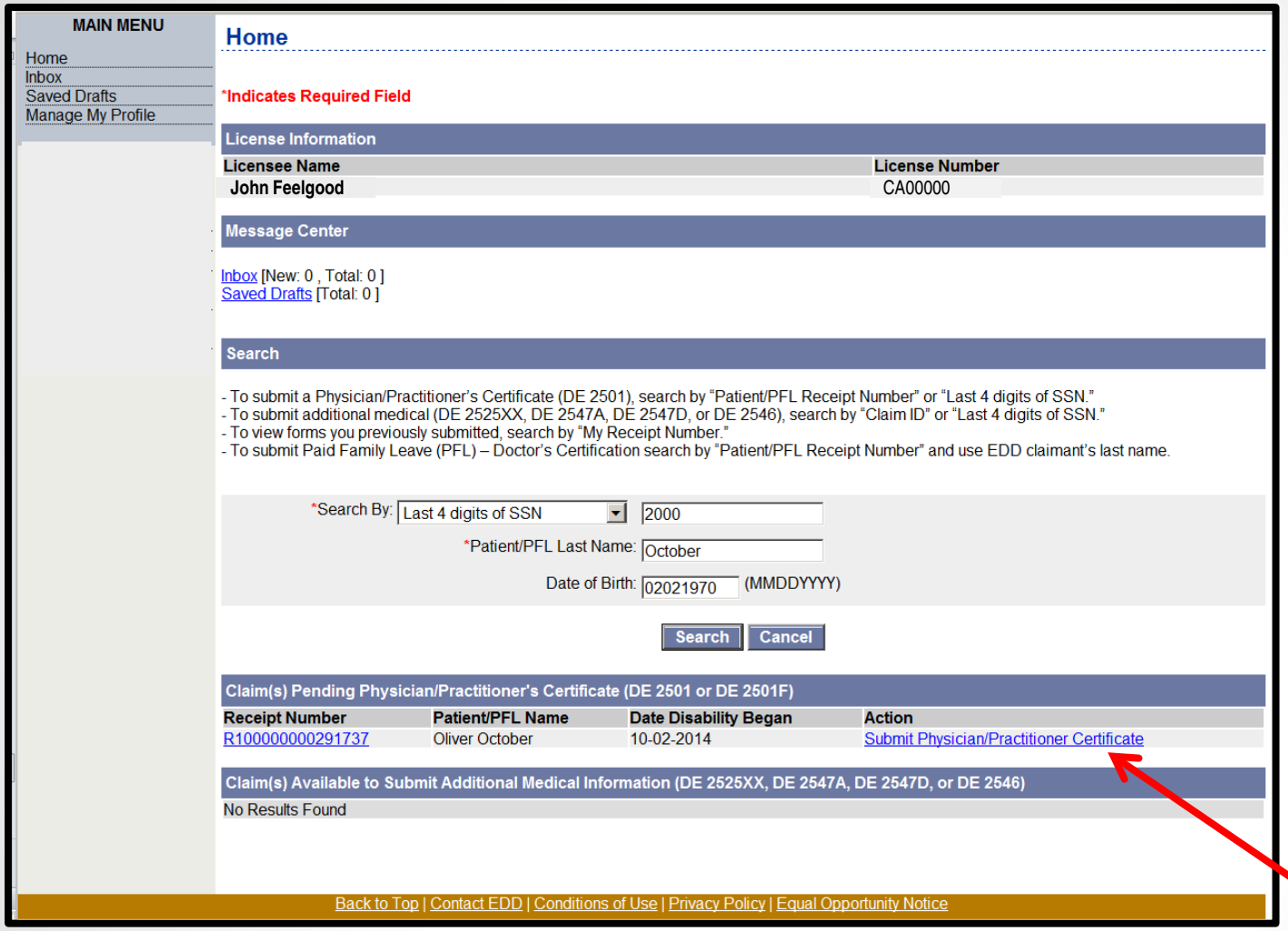


Physician/Practitioner Representatives

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**.



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.

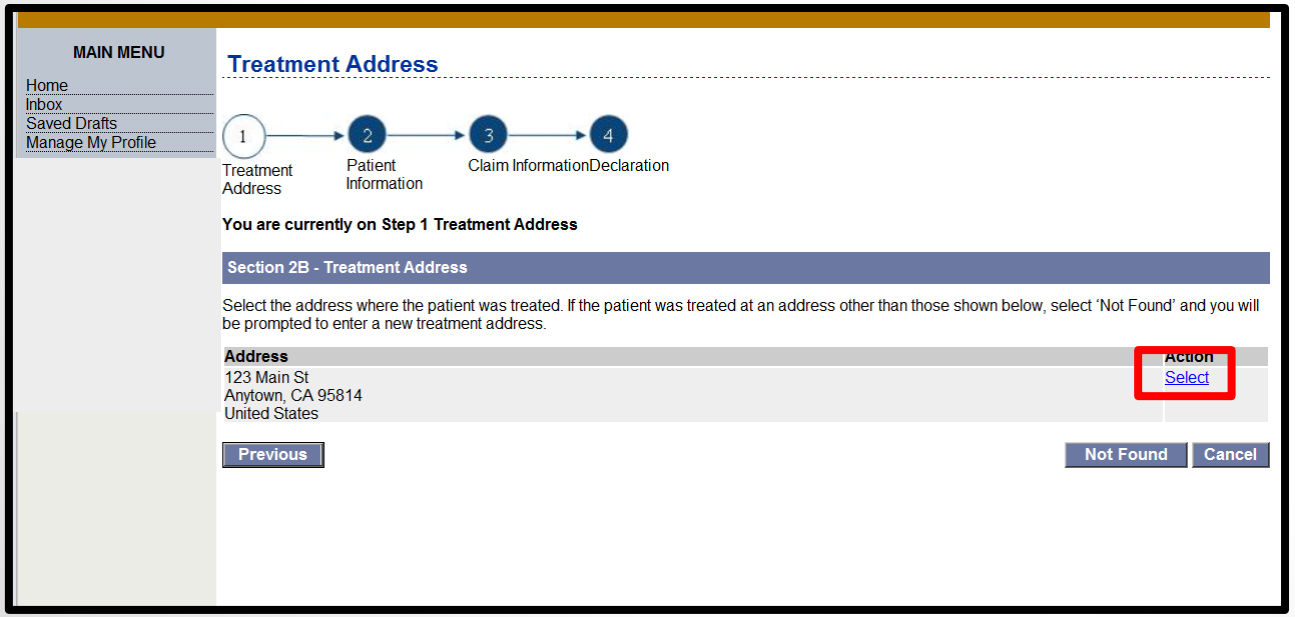
The **Receipt Number** link will allow you to view what the patient submitted on their portion of the DE 2501 Part A – Claimant's Statement.

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

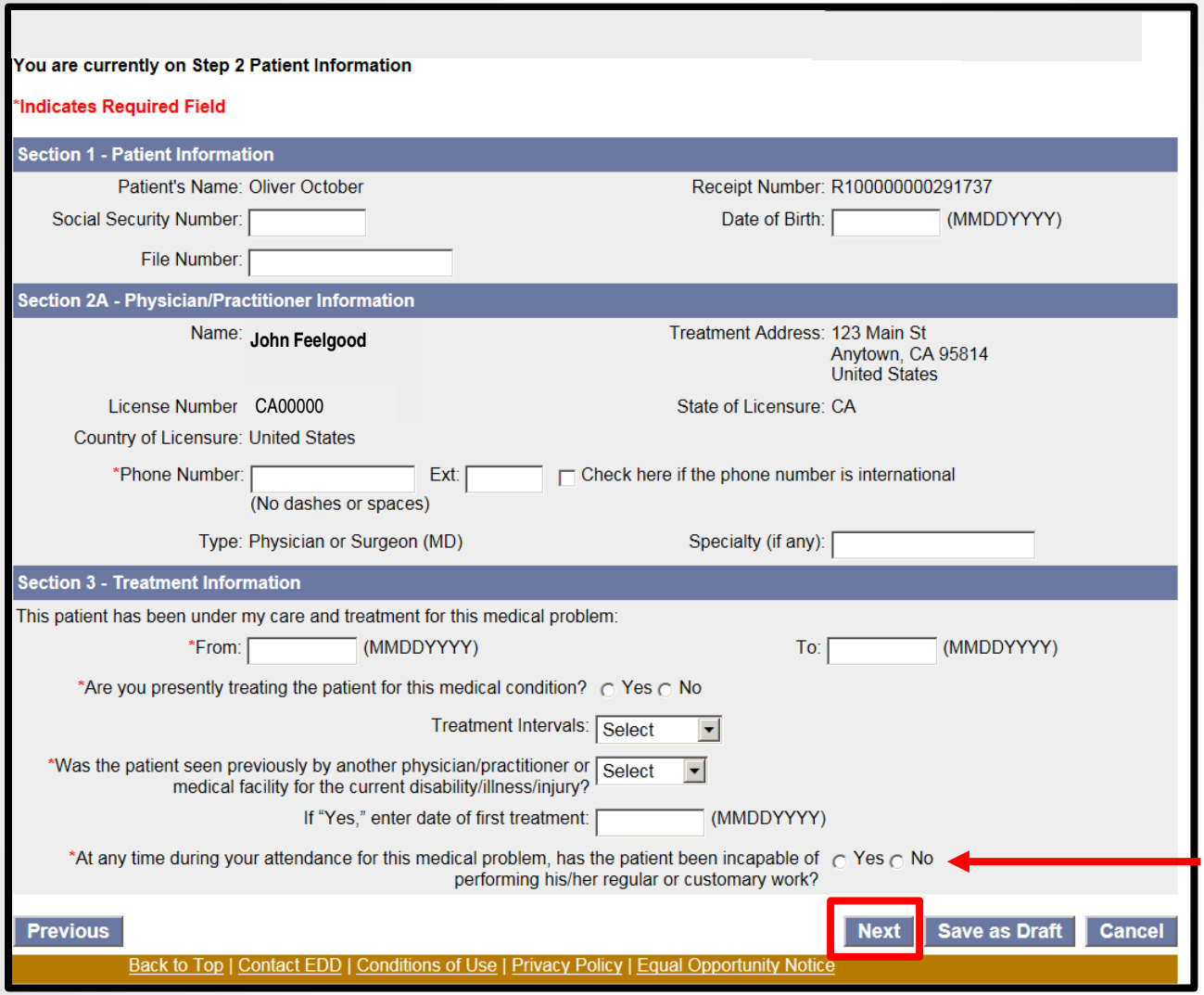
Note: If the certificate is already submitted by another user (i.e., physician/practitioner representative), the **Submit Physician/Practitioner Certificate** link will not be available.

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

Select **Next** to complete the certificate.



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



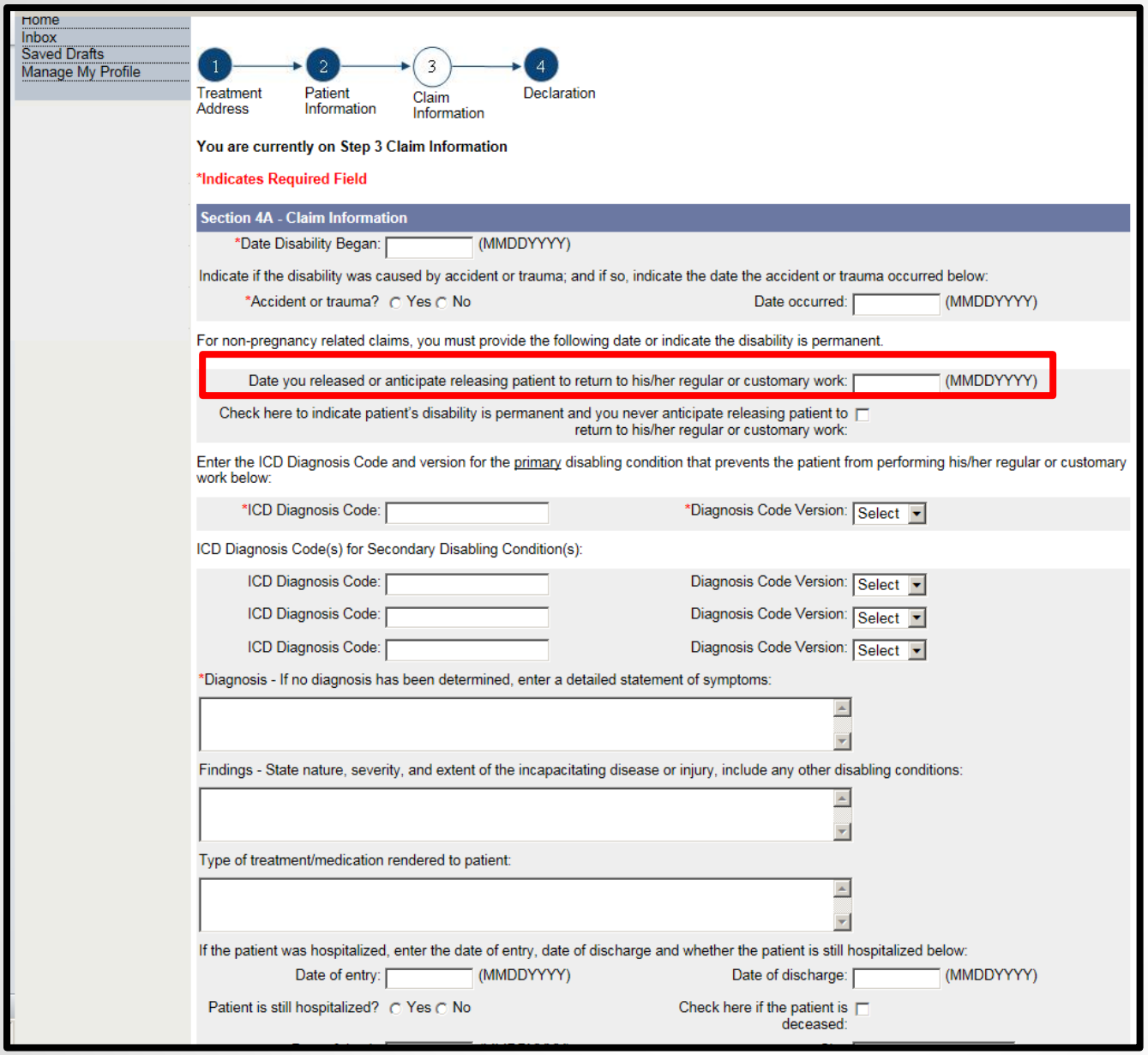
Complete the **Patient Information** section and select **Next**.

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

Tip: Select **Save as Draft** at any point in the process to complete the form at a later time.

Note: Marking **No** will end your submission and make patient ineligible for benefits.

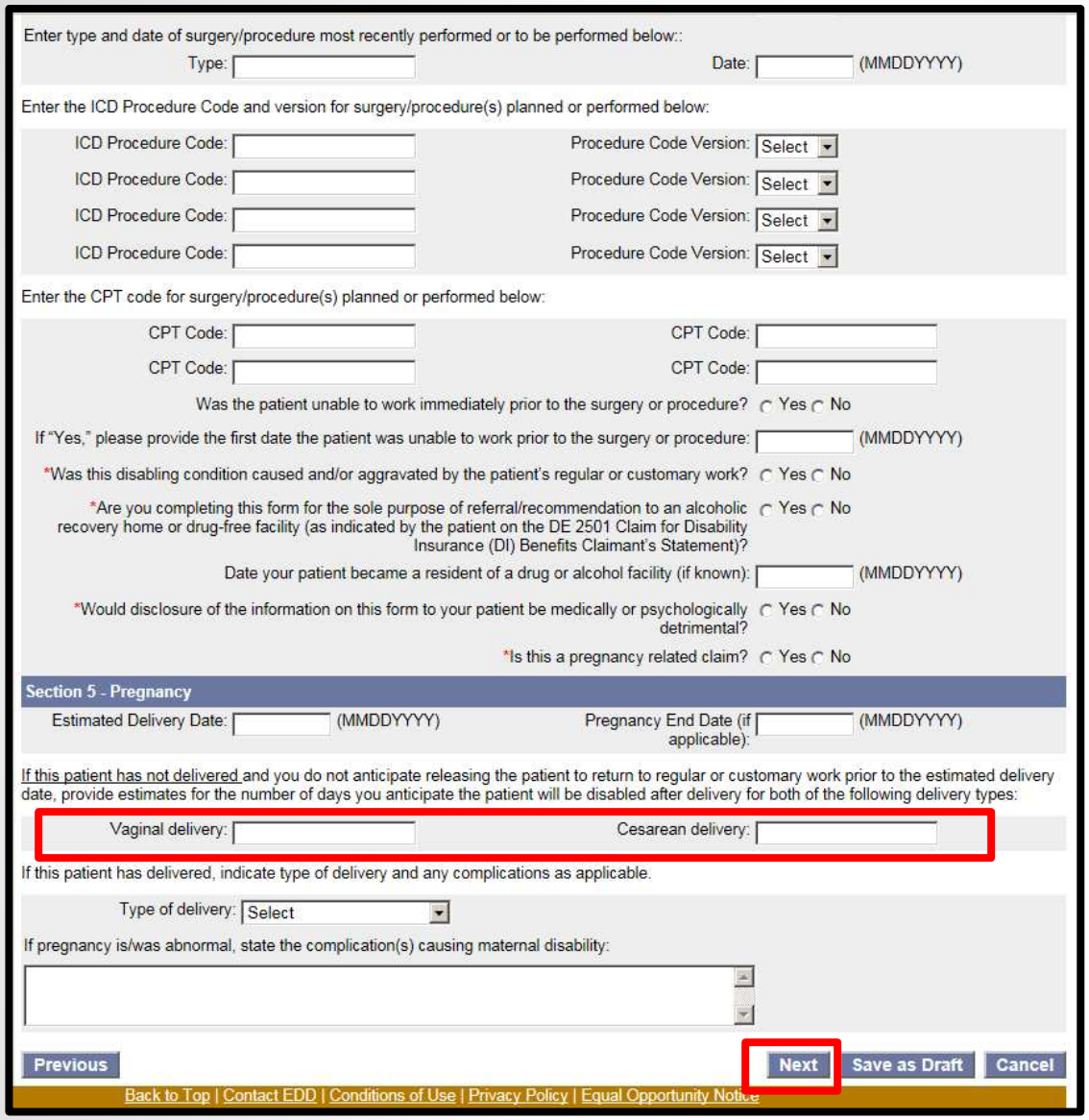
Note: Do not use the Back button on the browser. If you need to go to a previous screen, select the **Previous** button.



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.



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

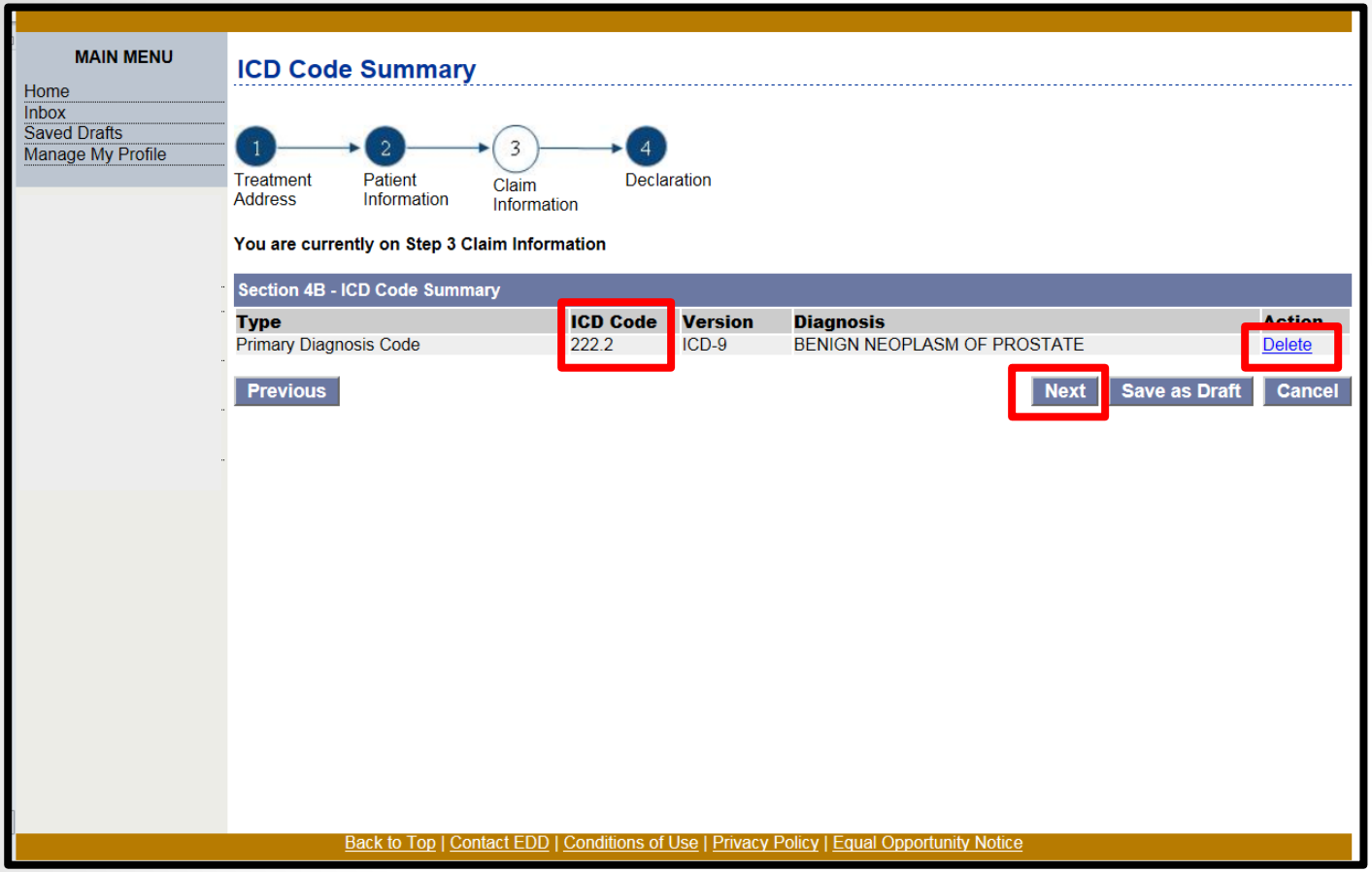
- Example: If the physician/practitioner allows the patient 6-8 weeks of postpartum disability, depending on the delivery type, then:

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

  OR

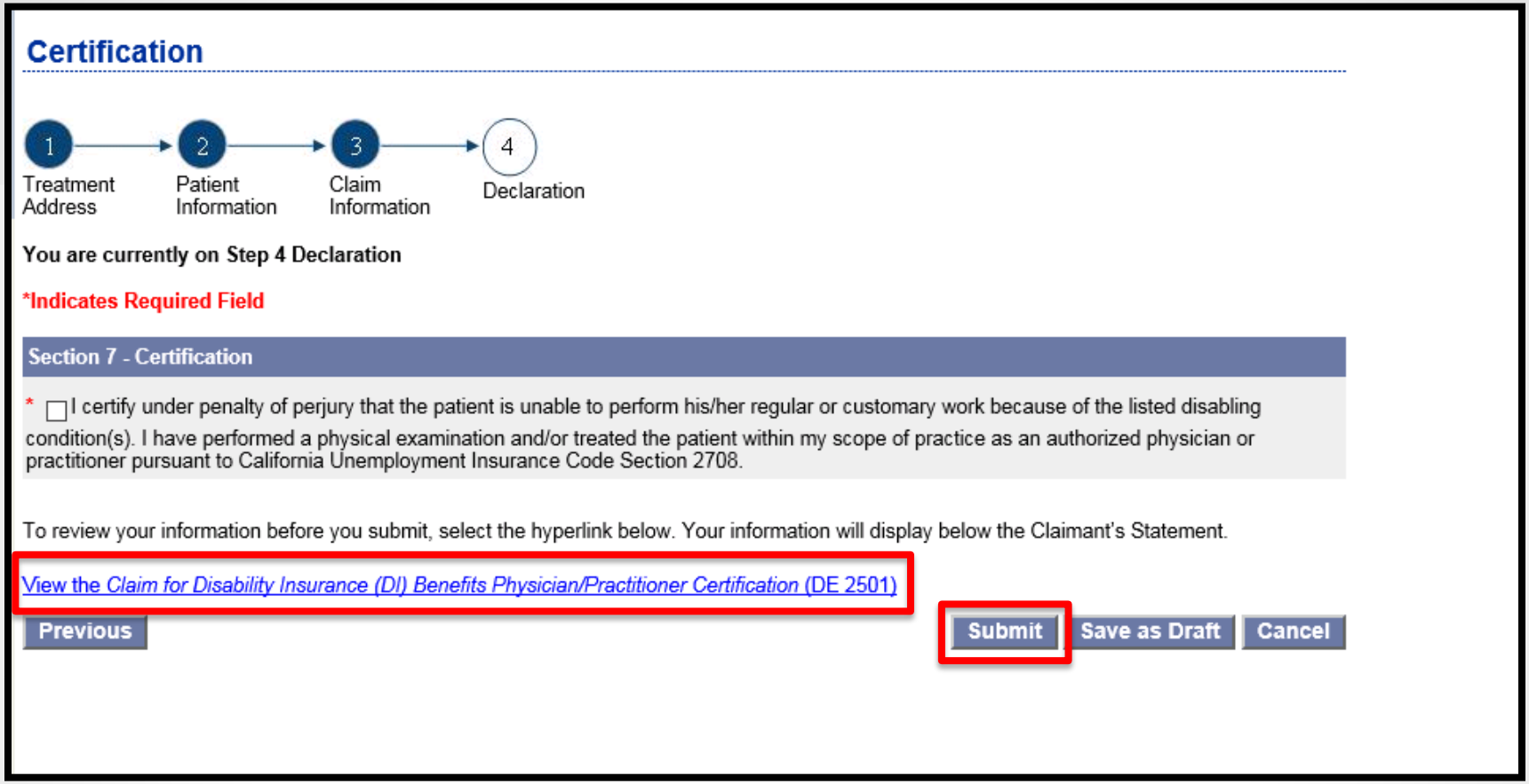
  - Enter the number 56 in the Cesarean Delivery field (8 weeks x 7 days a week = 56).

Select **Next**.



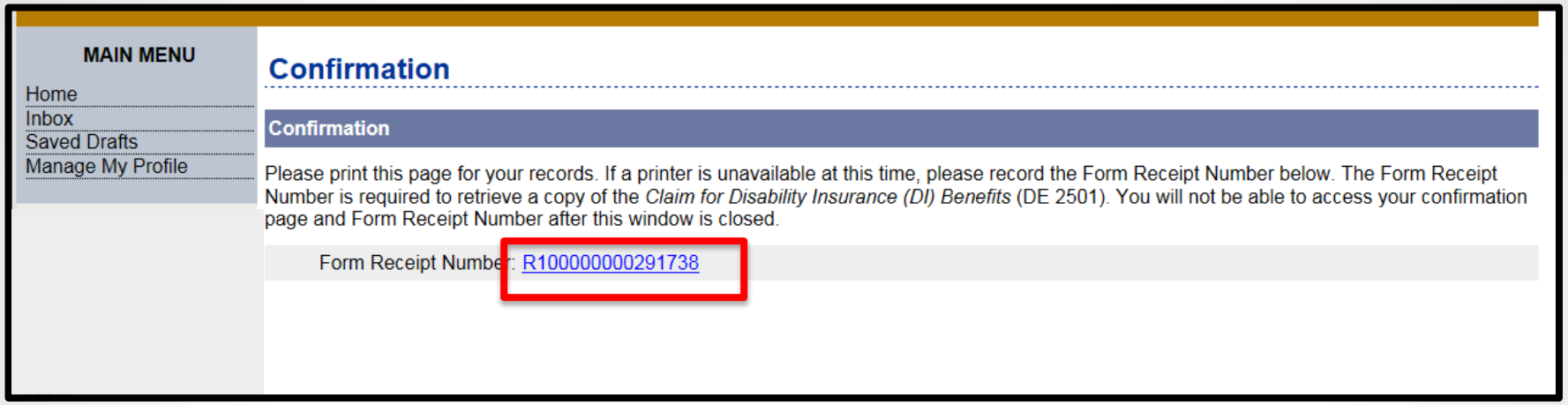
Verify the ICD code(s) is correct for the claim and select **Next**.

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



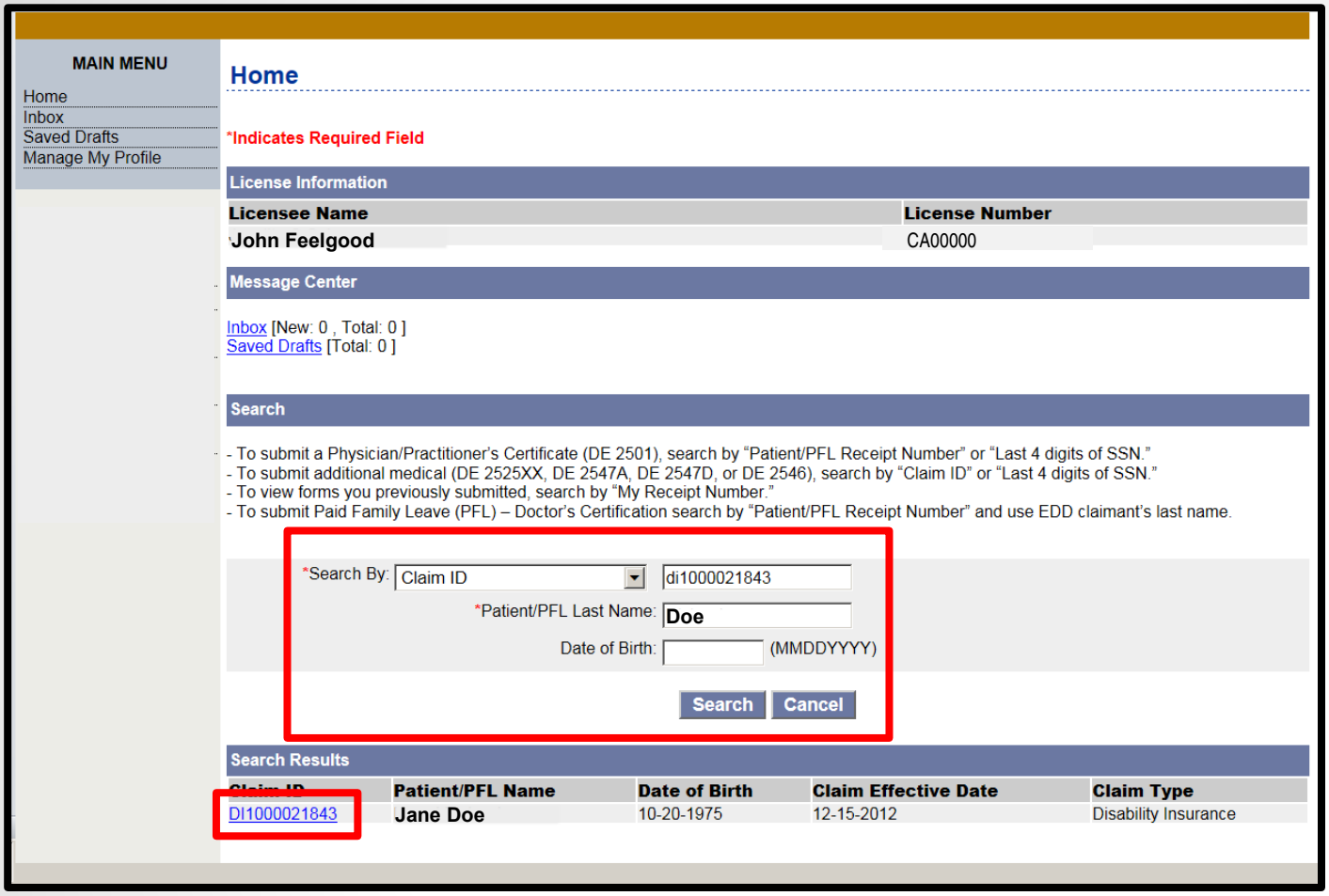
Once the form is completed, select the box in the **certification** section to authorize an electronic signature. Before submitting the form, you may view the form by selecting the link at the bottom of the page.

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



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

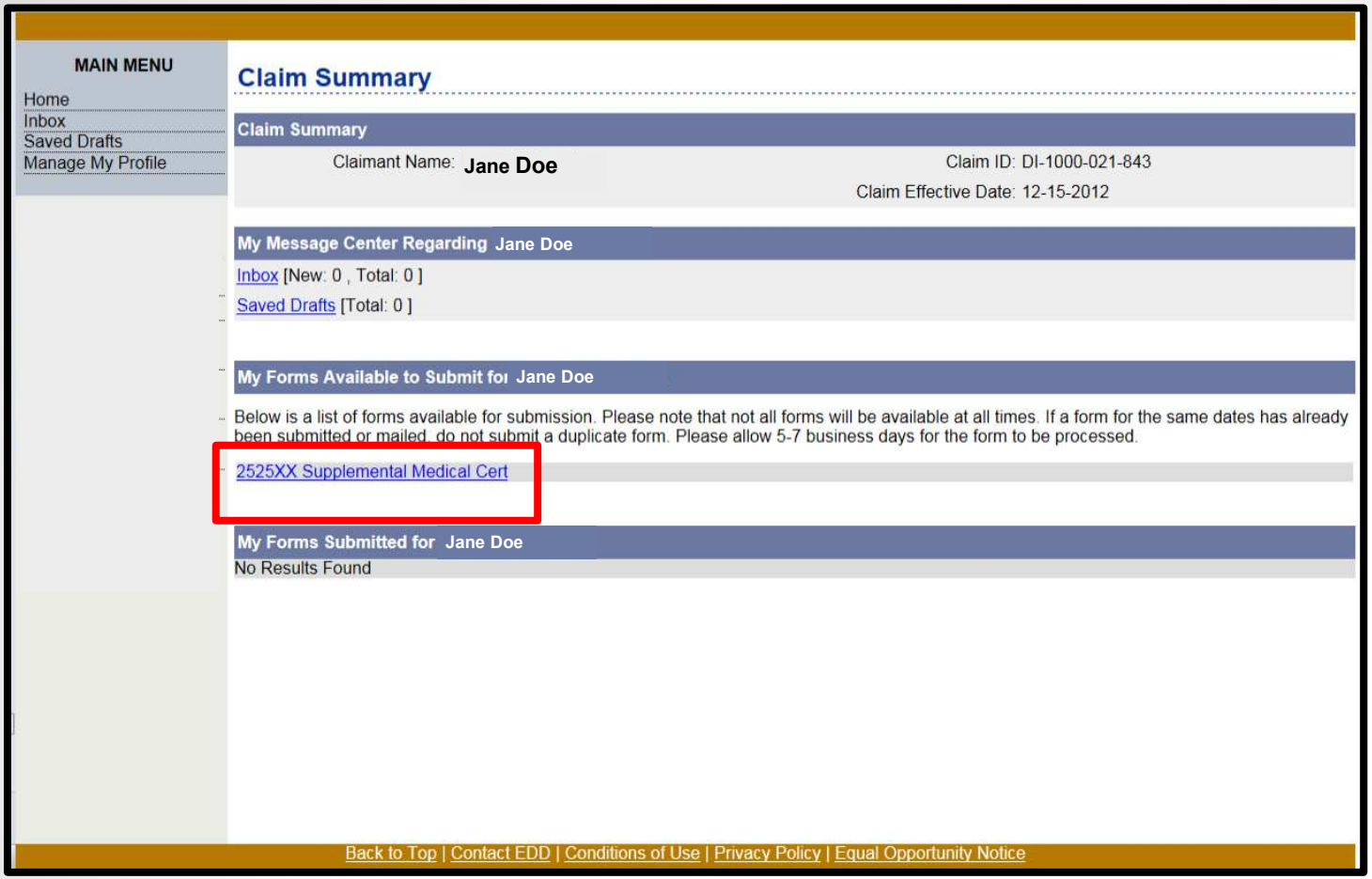


On the **Home** page, to submit a DE 2525XX – Supplemental Medical Certificate:

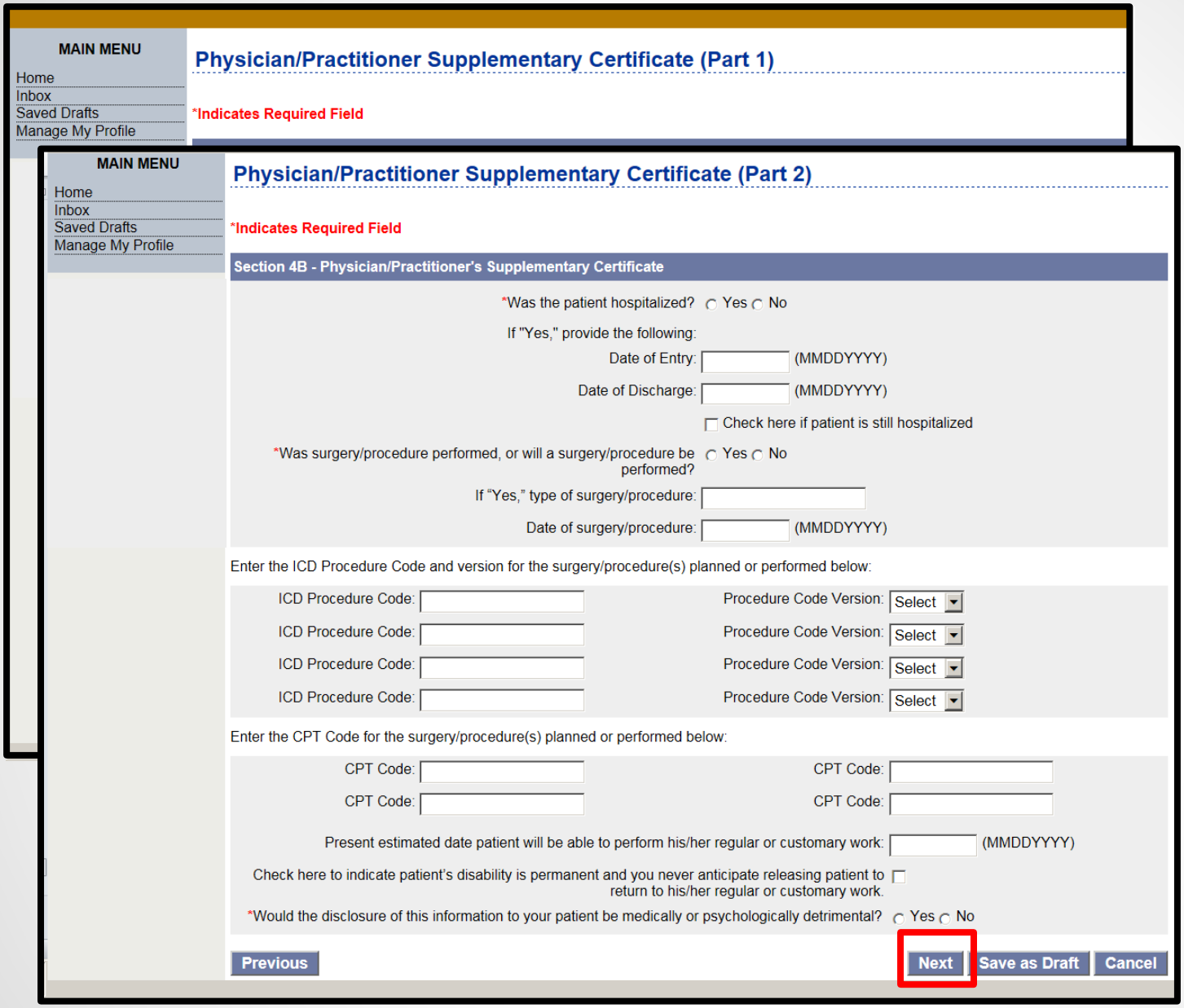
Select a preferred search method from the **Search By** drop down menu.

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

Then select the **Claim ID** link.



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



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

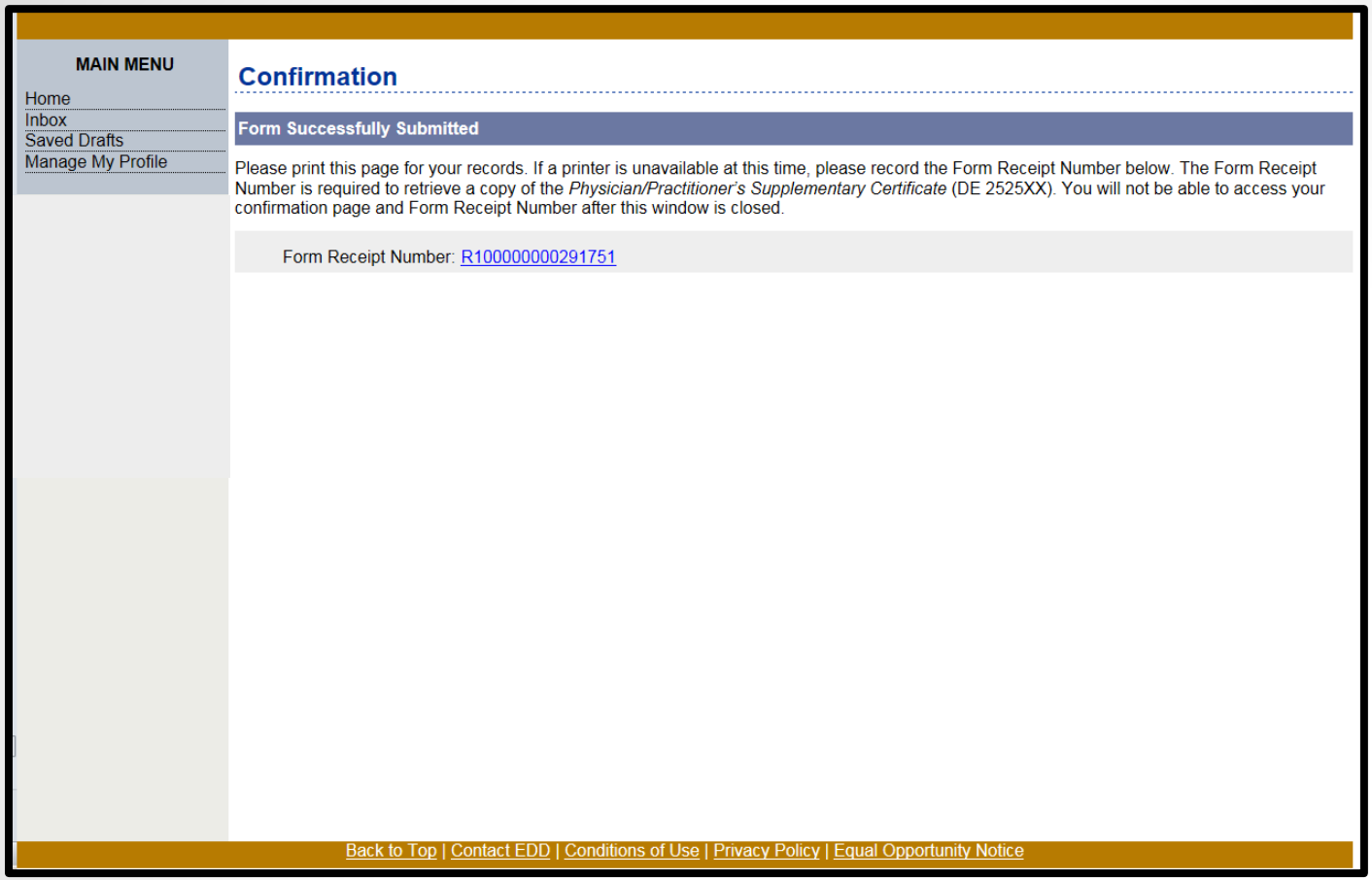
Mandatory fields are marked with a red asterisk (*).

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

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

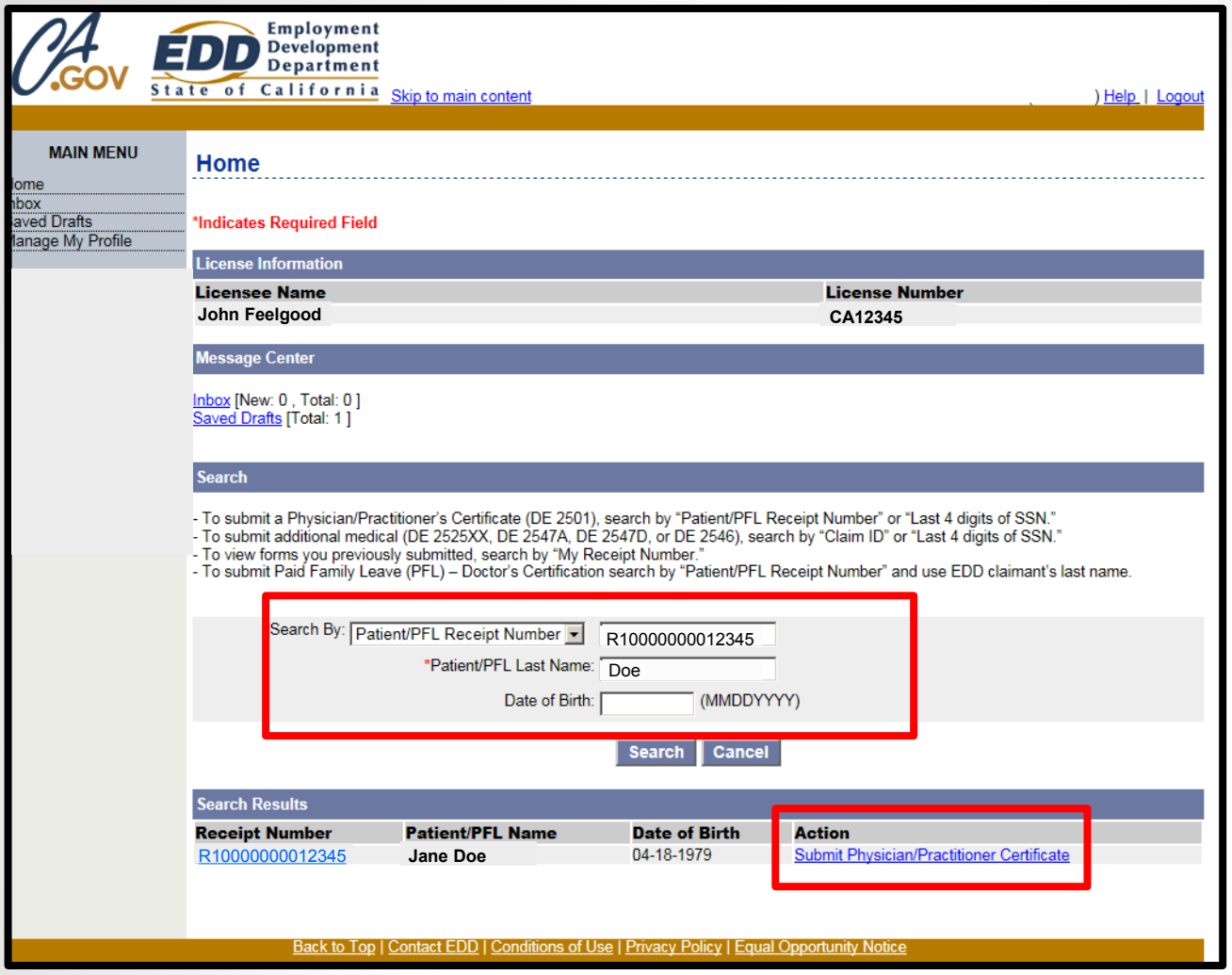
Before submitting the form, you may view the form by selecting the link at the bottom of the page.

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



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



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

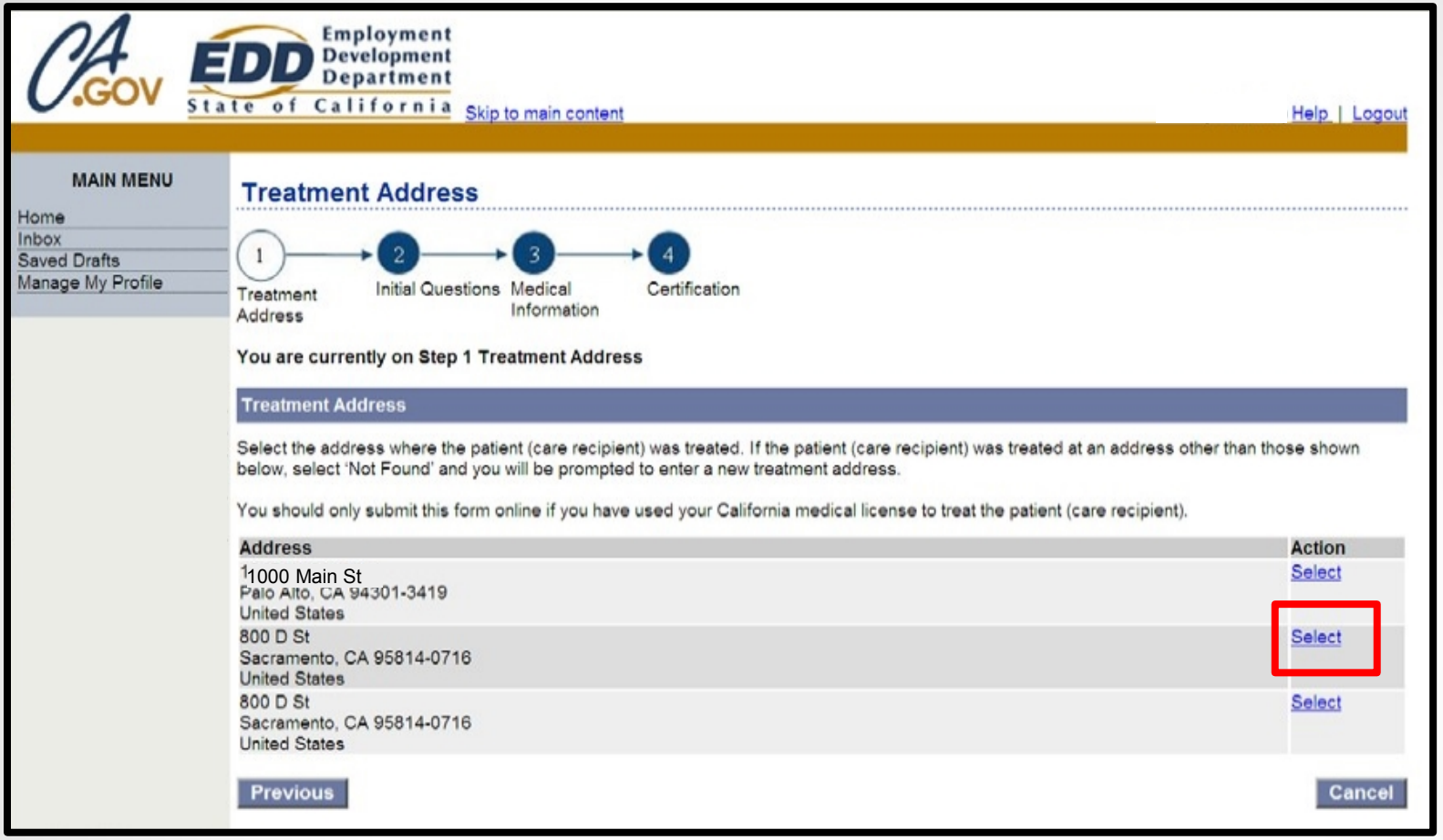
- Search by "Patient/PFL Receipt Number" to submit PFL forms for your patient's care provider.
- Search by the last four digits of the patient's SSN, date of birth, and last name.

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

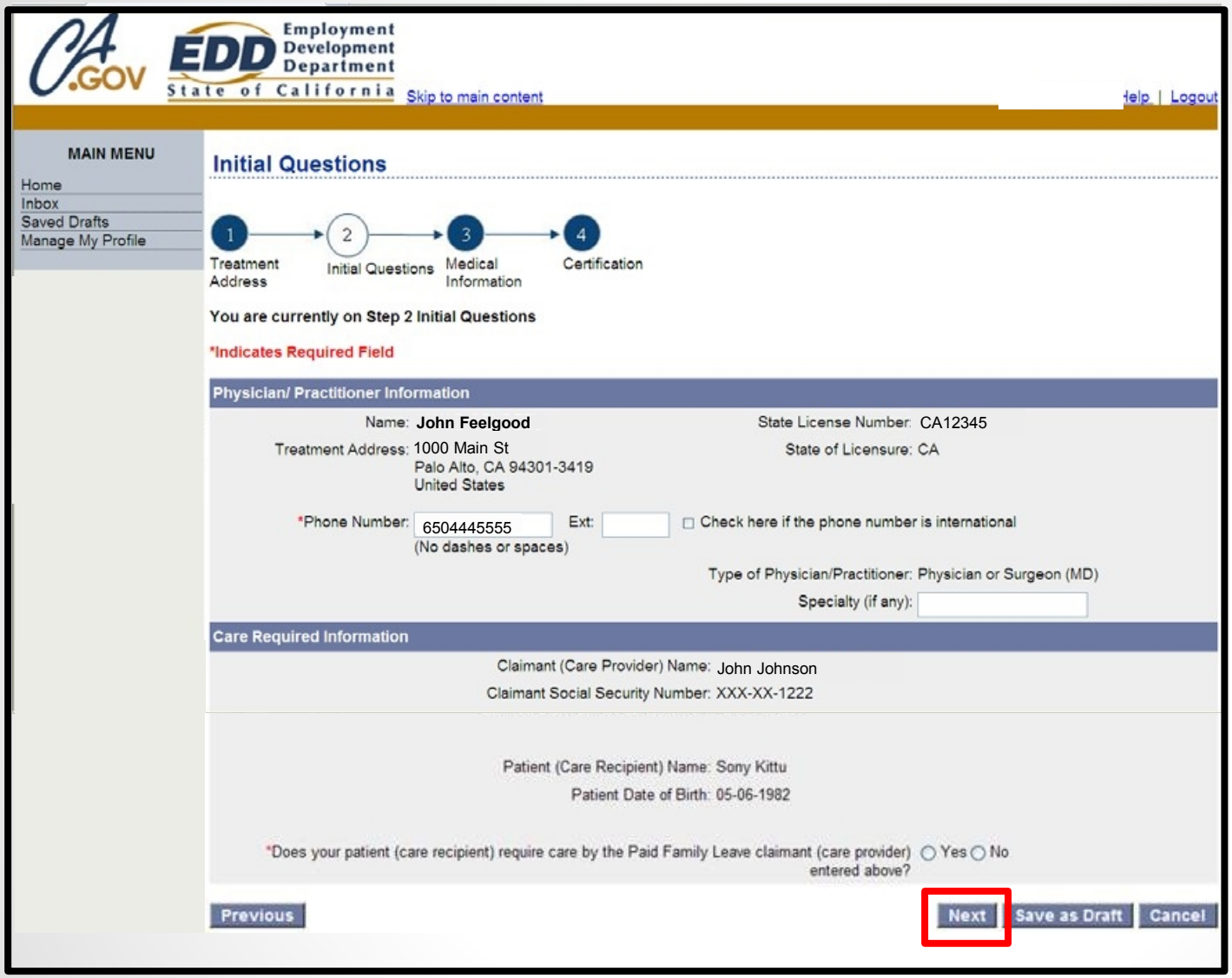
Note: In order to submit the physician/practitioner portion of the DE 2501F online, the patient's care provider must have already submitted their part of the DE 2501F.

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.

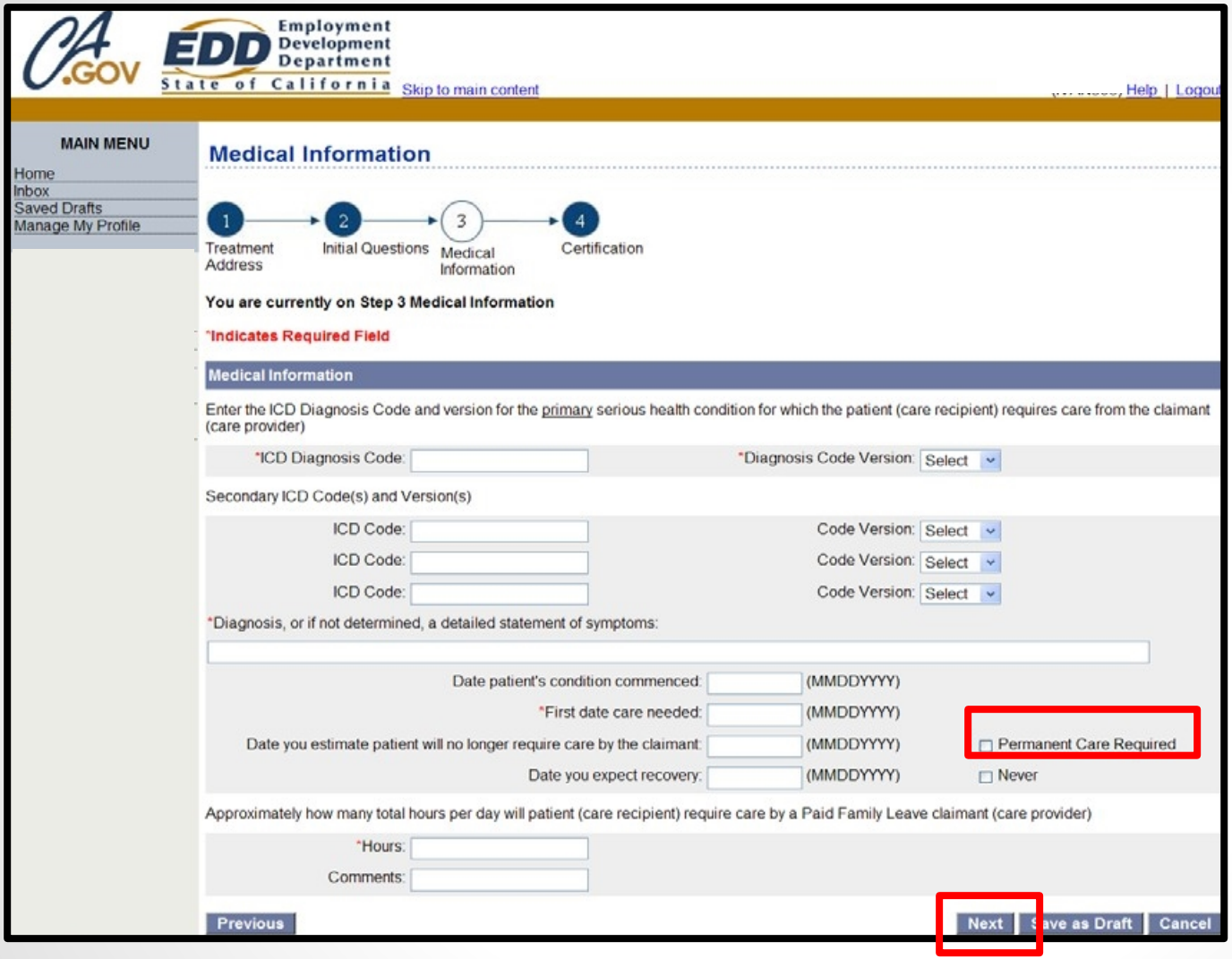


On the **Treatment Address** page, select the treatment address of where the patient is being treated.



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

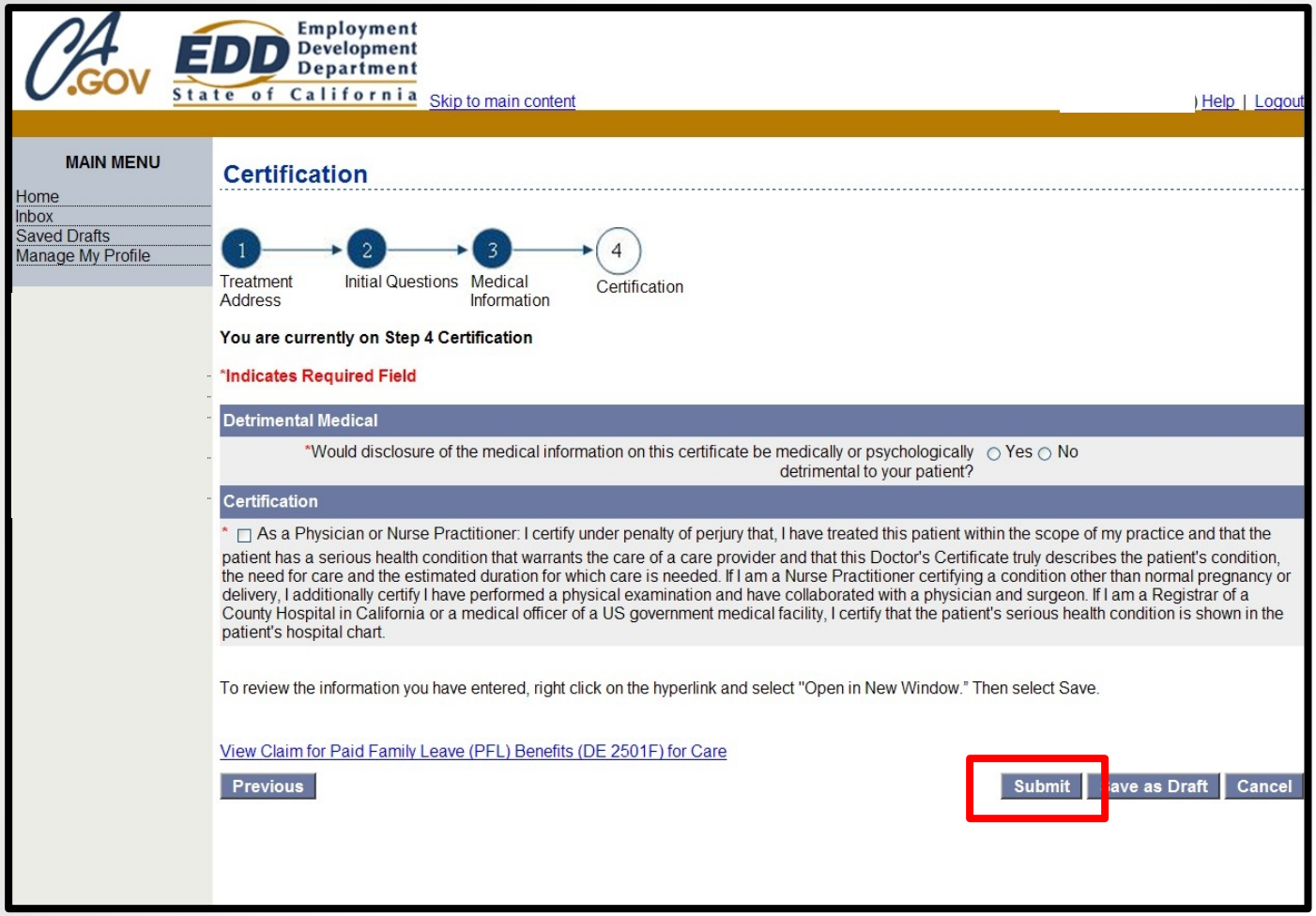
Mandatory fields are marked with a red asterisk (*).



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.

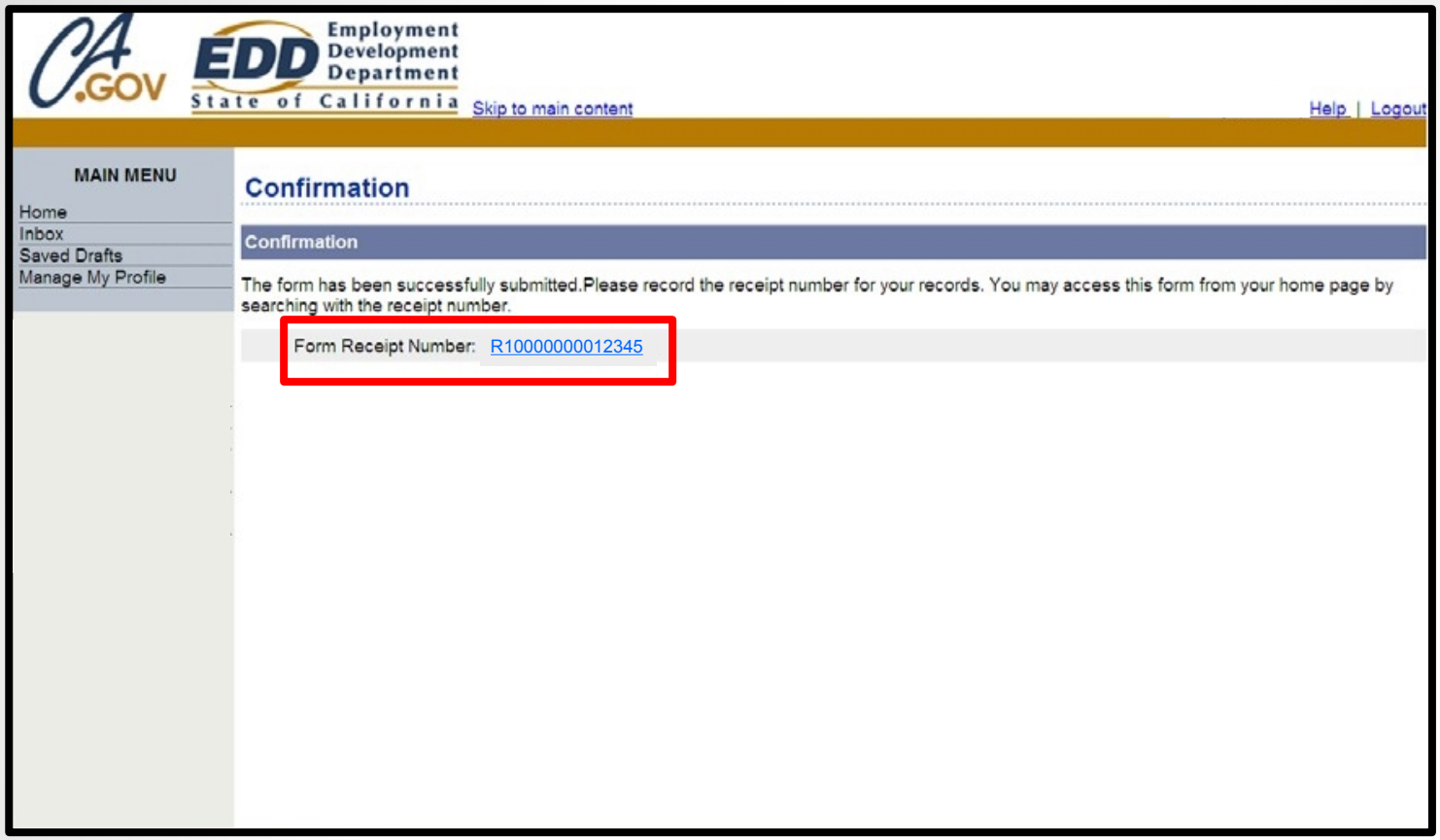
Complete all applicable fields, then select **Next**.



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.

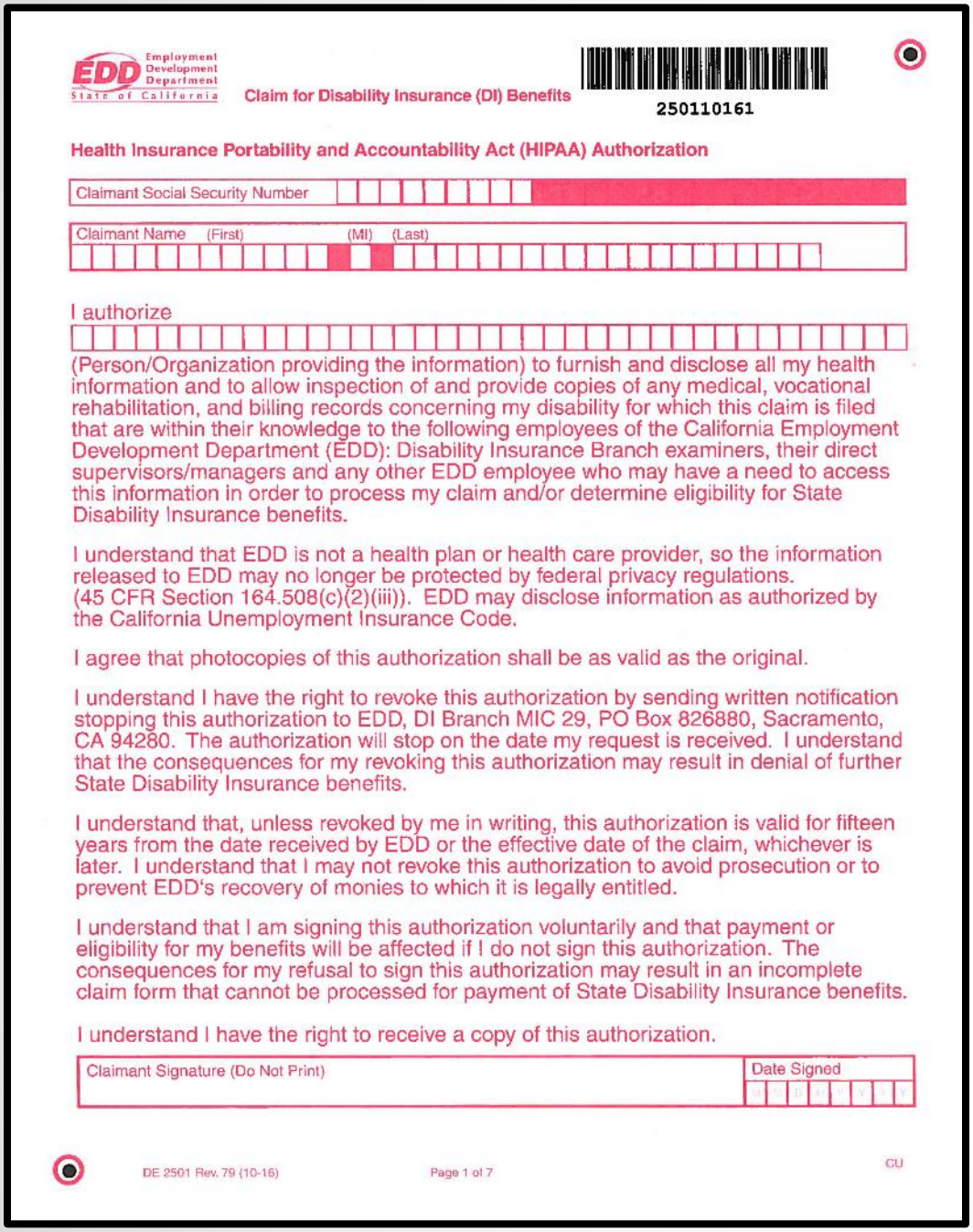


On the **Confirmation** screen, select the **Form Receipt Number** link to open a PDF printer-friendly view of the information that is submitted.

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.



Employment Development Department
State of California

Claim for Disability Insurance (DI) Benefits

250110161

Health Insurance Portability and Accountability Act (HIPAA) Authorization

Claimant Social Security Number

Claimant Name (First) (MI) (Last)

I authorize

(Person/Organization providing the information) to furnish and disclose all my health information and to allow inspection of and provide copies of any medical, vocational rehabilitation, and billing records concerning my disability for which this claim is filed that are within their knowledge to the following employees of the California Employment Development Department (EDD): Disability Insurance Branch examiners, their direct supervisors/managers and any other EDD employee who may have a need to access this information in order to process my claim and/or determine eligibility for State Disability Insurance benefits.

I understand that EDD is not a health plan or health care provider, so the information released to EDD may no longer be protected by federal privacy regulations. (45 CFR Section 164.508(c)(2)(iii)). EDD may disclose information as authorized by the California Unemployment Insurance Code.

I agree that photocopies of this authorization shall be as valid as the original.

I understand I have the right to revoke this authorization by sending written notification stopping this authorization to EDD, DI Branch MIC 29, PO Box 826880, Sacramento, CA 94280. The authorization will stop on the date my request is received. I understand that the consequences for my revoking this authorization may result in denial of further State Disability Insurance benefits.

I understand that, unless revoked by me in writing, this authorization is valid for fifteen years from the date received by EDD or the effective date of the claim, whichever is later. I understand that I may not revoke this authorization to avoid prosecution or to prevent EDD's recovery of monies to which it is legally entitled.

I understand that I am signing this authorization voluntarily and that payment or eligibility for my benefits will be affected if I do not sign this authorization. The consequences for my refusal to sign this authorization may result in an incomplete claim form that cannot be processed for payment of State Disability Insurance benefits.

I understand I have the right to receive a copy of this authorization.

Claimant Signature (Do Not Print) | Date Signed

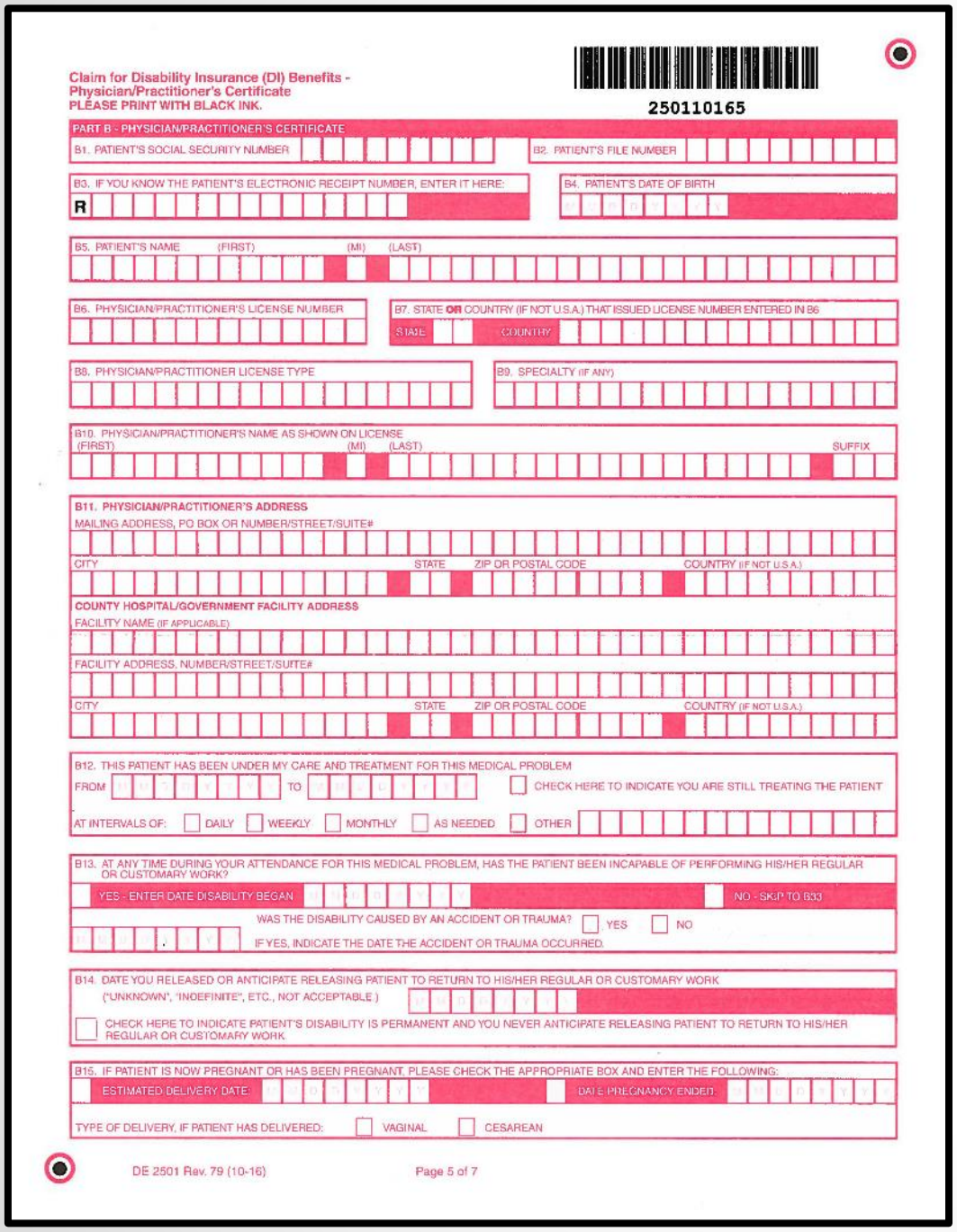
DE 2501 Rev. 79 (10-16) Page 1 of 7 CU

Claim for Disability Insurance (DI) Benefits (DE 2501)

Part A - Claimant's Statement, pages 1-4.

Page 1 – The Health Insurance Portability and Accountability (HIPAA) Authorization needs to be signed by the claimant.

Do not photocopy or fax this form.



Claim for Disability Insurance (DI) Benefits -
Physician/Practitioner's Certificate
PLEASE PRINT WITH BLACK INK.

250110165

PART B - PHYSICIAN/PRACTITIONER'S CERTIFICATE

B1. PATIENT'S SOCIAL SECURITY NUMBER

B2. PATIENT'S FILE NUMBER

B3. IF YOU KNOW THE PATIENT'S ELECTRONIC RECEIPT NUMBER, ENTER IT HERE:
R

B4. PATIENT'S DATE OF BIRTH
M M D D Y Y

B5. PATIENT'S NAME (FIRST) (MI) (LAST)

B6. PHYSICIAN/PRACTITIONER'S LICENSE NUMBER

B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED IN B6
STATE COUNTRY

B8. PHYSICIAN/PRACTITIONER LICENSE TYPE

B9. SPECIALTY (IF ANY)

B10. PHYSICIAN/PRACTITIONER'S NAME AS SHOWN ON LICENSE
(FIRST) (MI) (LAST) SUFFIX

B11. PHYSICIAN/PRACTITIONER'S ADDRESS
MAILING ADDRESS, PO BOX OR NUMBER/STREET/SUITE#

CITY STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)

COUNTY HOSPITAL/GOVERNMENT FACILITY ADDRESS
FACILITY NAME (IF APPLICABLE)

FACILITY ADDRESS, NUMBER/STREET/SUITE#

CITY STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)

B12. THIS PATIENT HAS BEEN UNDER MY CARE AND TREATMENT FOR THIS MEDICAL PROBLEM
FROM M M D D Y Y TO M M D D Y Y ☐ CHECK HERE TO INDICATE YOU ARE STILL TREATING THE PATIENT

AT INTERVALS OF: ☐ DAILY ☐ WEEKLY ☐ MONTHLY ☐ AS NEEDED ☐ OTHER

B13. AT ANY TIME DURING YOUR ATTENDANCE FOR THIS MEDICAL PROBLEM, HAS THE PATIENT BEEN INCAPABLE OF PERFORMING HIS/HER REGULAR OR CUSTOMARY WORK?

YES - ENTER DATE DISABILITY BEGAN M M D D Y Y NO - SKIP TO B33

WAS THE DISABILITY CAUSED BY AN ACCIDENT OR TRAUMA? ☐ YES ☐ NO

M M D D Y Y IF YES, INDICATE THE DATE THE ACCIDENT OR TRAUMA OCCURRED.

B14. DATE YOU RELEASED OR ANTICIPATE RELEASING PATIENT TO RETURN TO HIS/HER REGULAR OR CUSTOMARY WORK
("UNKNOWN", "INDEFINITE", ETC., NOT ACCEPTABLE) M M D D Y Y

☐ CHECK HERE TO INDICATE PATIENT'S DISABILITY IS PERMANENT AND YOU NEVER ANTICIPATE RELEASING PATIENT TO RETURN TO HIS/HER REGULAR OR CUSTOMARY WORK

B15. IF PATIENT IS NOW PREGNANT OR HAS BEEN PREGNANT, PLEASE CHECK THE APPROPRIATE BOX AND ENTER THE FOLLOWING:

ESTIMATED DELIVERY DATE: M M D D Y Y DATE PREGNANCY ENDED: M M D D Y Y

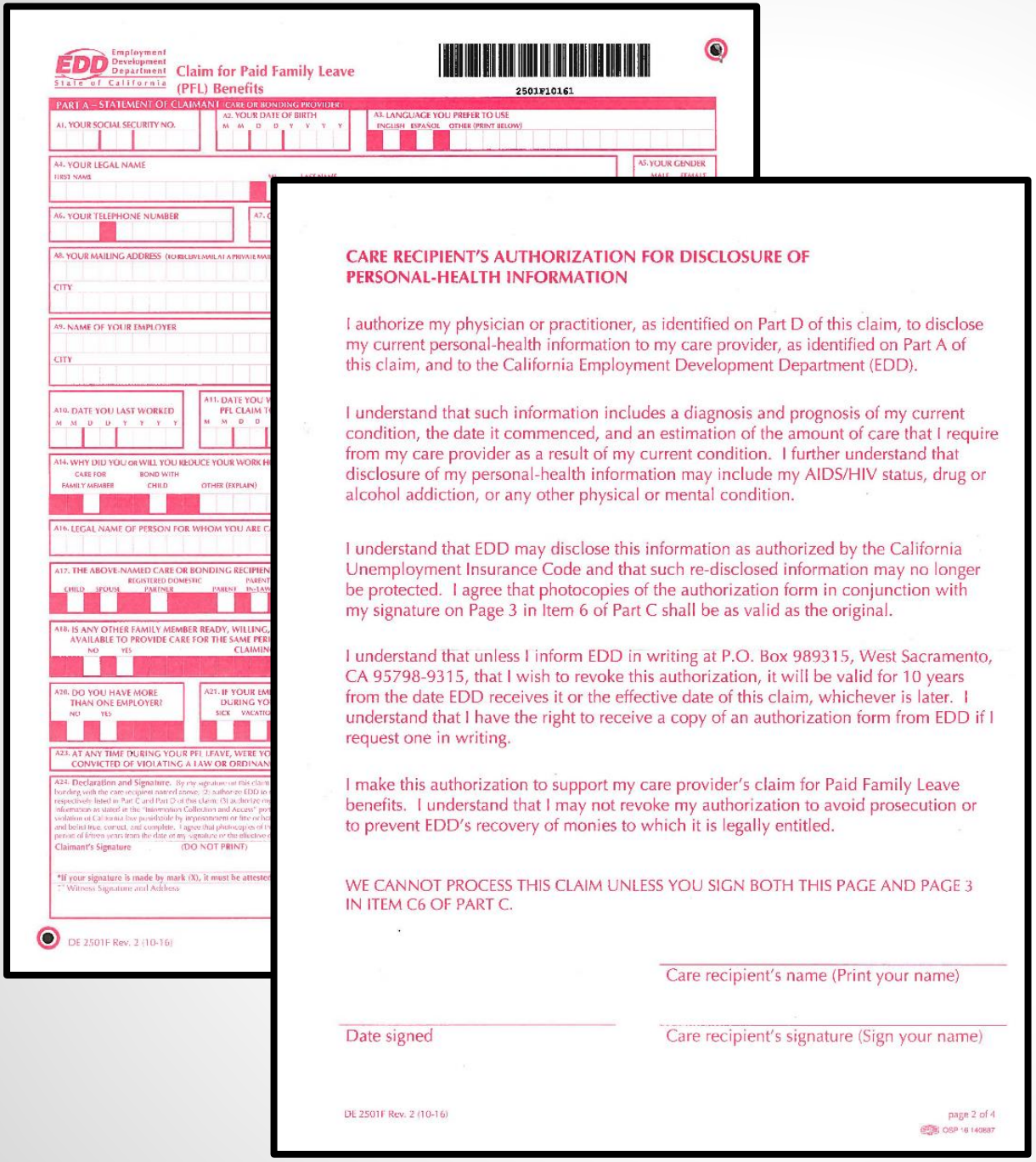
TYPE OF DELIVERY, IF PATIENT HAS DELIVERED: ☐ VAGINAL ☐ CESAREAN

DE 2501 Rev. 79 (10-16) Page 5 of 7

Claim for Disability Insurance (DI) Benefits (DE 2501)

Part B - Physician's/Practitioner's Certificate, pages 5-7.

All appropriate information including dates, diagnosis, and treatment codes must be completed by the physician/practitioner. The physician/practitioner needs to sign page 7.



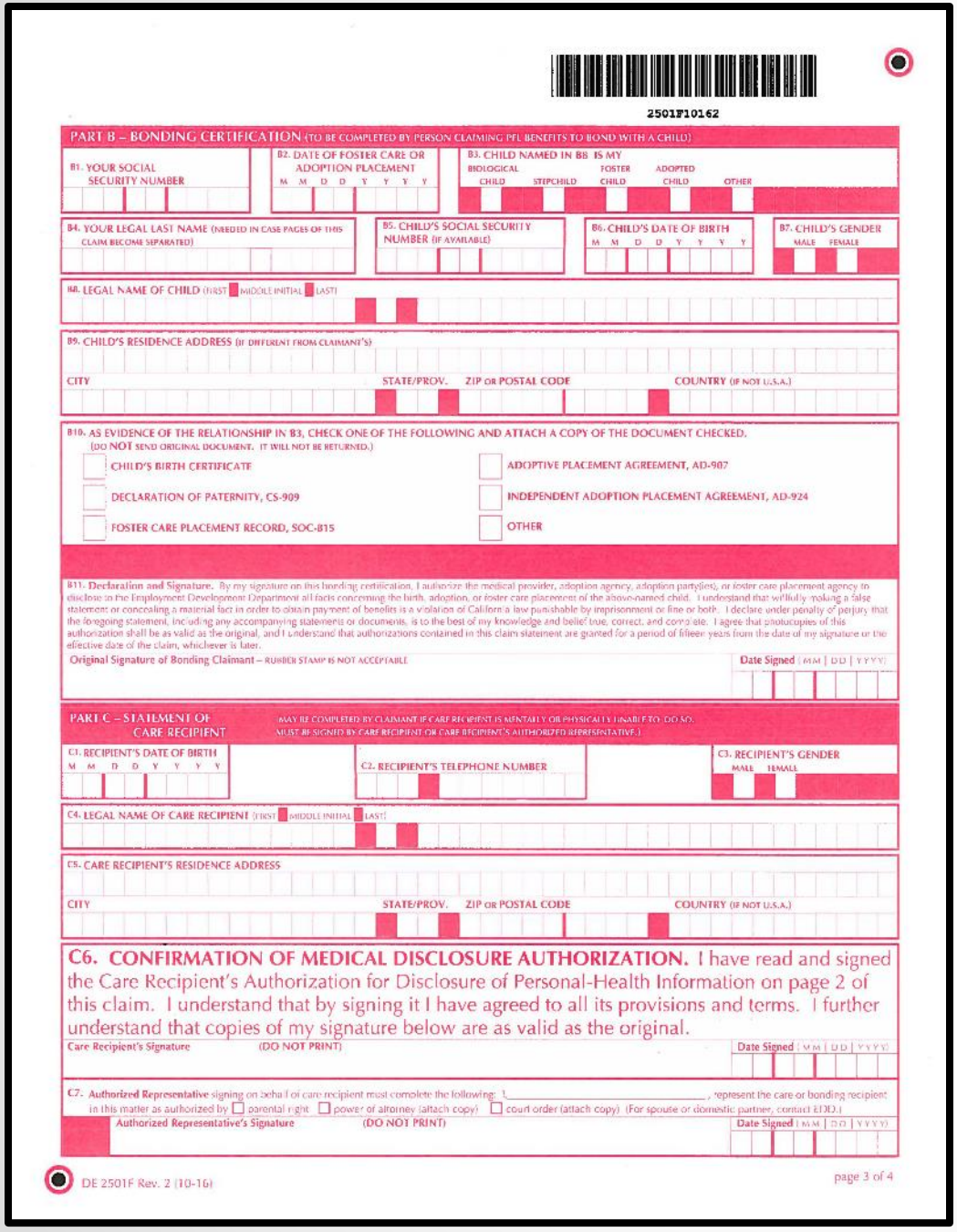
Claim for Paid Family Leave (PFL) Benefits (DE 2501F)

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 B8 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 part(y)(ies), or foster care placement agency to disclose to 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 (M M D D Y Y Y Y)

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 (M M D D Y Y Y Y)

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 (M M D D Y Y Y Y)

DE 2501F Rev. 2 (10-16) page 3 of 4

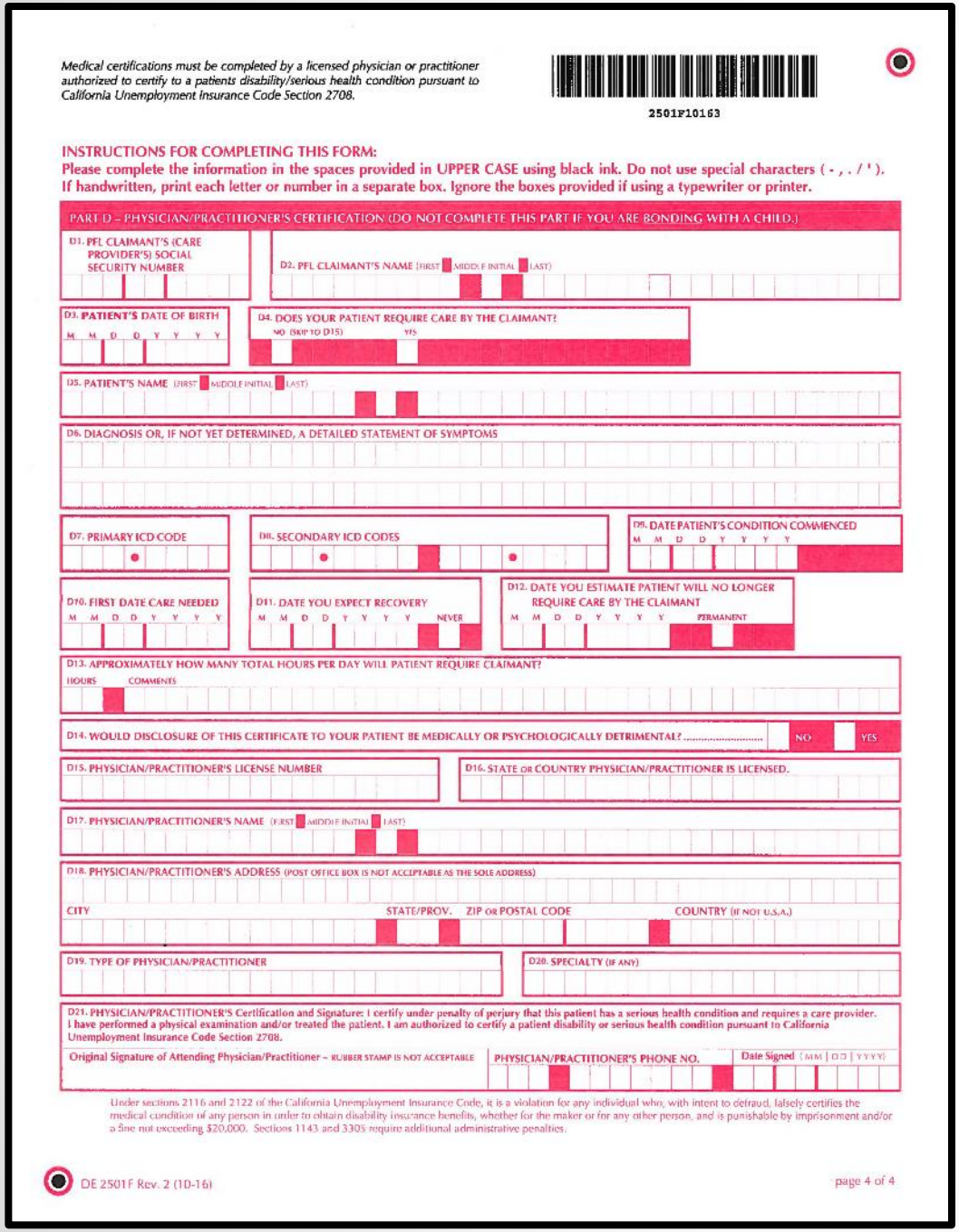
Claim for Paid Family Leave (PFL) Benefits (DE 2501F)

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 patients disability/serious health condition pursuant to California Unemployment Insurance Code Section 2708.

2501F10163

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 M M D D Y Y Y Y

D4. DOES YOUR PATIENT REQUIRE CARE BY THE CLAIMANT? NO (SKIP TO D15) YES

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 M M D D Y Y Y Y

D10. FIRST DATE CARE NEEDED M M D D Y Y Y Y

D11. DATE YOU EXPECT RECOVERY M M D D Y Y Y Y NEVER

D12. DATE YOU ESTIMATE PATIENT WILL NO LONGER REQUIRE CARE BY THE CLAIMANT M M D D Y Y Y Y PERMANENT

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

D14. WOULD DISCLOSURE OF THIS CERTIFICATE TO YOUR PATIENT BE MEDICALLY OR PSYCHOLOGICALLY DETRIMENTAL? ..... NO YES

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)
CITY STATE/PROV. ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)

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 3305 require additional administrative penalties.

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

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.