Long Term Disability Claim Form
Attending Physician's Statement

Section 1: History

Patient last name	First name	M.I.	Birth date (MMDDYYYY)

Date symptoms first appeared or accident happened (MMDDYYYY)	Date patient ceased work because of disability (MMDDYYYY)

Has patient ever had same or similar condition? ☐ Yes ☐ No
If yes, state when and describe: _____

Is condition due to injury or sickness arising out of patient's employment? ☐ Yes ☐ No ☐ Unknown

Names and addresses of other treating physicians

Section 2: Diagnosis — If disabling condition is due to a mental or nervous disorder, the attached *Functional Capabilities Evaluation* and *Mental Status Questionnaire* sections must also be completed.

Diagnosis (including complications)	Subjective symptoms	If pregnancy, estimated date of delivery

Objective findings (including current X-rays, EKGs, laboratory data and any clinical findings)

Section 3: Treatment

Date of first visit (MMDDYYYY)	Date of last visit (MMDDYYYY)	Frequency
		☐ Weekly ☐ Monthly ☐ Other: _____

Nature of treatment (Including surgery and medications prescribed, if any)

Section 4: Progress

Patient's present condition	Is patient?
☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed	☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined

Is patient mentally competent to endorse checks and direct proceeds thereof? ☐ Yes ☐ No

Has patient been hospital confined? ☐ Yes ☐ No If yes, complete the following.

Hospital name	Confined from (MMDDYYYY)	Through (MMDDYYYY)

Hospital street address	City	State	ZIP code

Section 5: Cardiac

Functional capacity (American Heart Association)	Blood pressure last visit: _____/_____ (systolic/diastolic
☐ Class 1 (no limitations) ☐ Class 2 (slight limitations) ☐ Class 3 (marked limitations) ☐ Class 4 (complete limitations)	

Section 6: Impairments

Physical impairments
☐ Class 1 - No limitations of functional capacity; capable of heavy work* no restrictions (0-10%)
☐ Class 2 - Medium manual activity* (15-30%)
☐ Class 3 - Slight limitation of functional capacity; capable of light work* (35-55%)
☐ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity (60-70%)
☐ Class 5 - Severe limitation of functional capacity; incapable of minimum (sedentary*) activity (75-100%)
Remarks:

*As defined in *Federal Dictionary of Occupational Titles.*

Long Term Disability Claim Form
Attending Physician's Statement (continued)

Section 6: Impairments (continued)

Mental impairments (if any):

a. Please define "stress" as it applies to this claimant and in light of his/her job requirements.

b. What stress and problems in interpersonal relations has claimant had on job?

- ☐ Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations)
- ☐ Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
- ☐ Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
- ☐ Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
- ☐ Class 5 - Patient has significant loss of psychological, physiological personal and social adjustment (severe limitations)

Section 7: Rehab

Is patient a suitable candidate for occupational rehabilitation? ☐ 1 month ☐ 1-3 months ☐ 3-6 months ☐ Never

When could trial employment commence?

Patient's own job: (MMDDYYYY) ☐ Full-time ☐ Part-time

Any other work: (MMDDYYYY) ☐ Full-time ☐ Part-time

Section 8: Any additional remarks

Limitations, therapy, etc.

Section 9: Physician information

Printed attending physician name	Degree	Phone no.	
Street address	City	State	ZIP code
Signature of attending physician **X**		Date (MMDDYYYY)	

Long Term Disability Claim Form
Mental Status Questionnaire

Needs to be completed only if condition is due to mental or nervous disorder.

Section 1: Patient information

Patient last name	First name	M.I.	Birth date (MMDDYYYY)

Date treatment began (MMDDYYYY)	Frequency	Nature of treatment

Diagnosis (Use DSM IV Multi-axial evaluation nomenclature and code numbers)

Section 2: Please respond to all items. Use additional pages as necessary.

State patient's initial reason for seeking treatment.

Describe patient's current condition and mental status.

Medications: Please list current medications, dosage and dates begun.

Please summarize current treatment goals.

Comments

Signature of physician	Date (MMDDYYYY)
X	

Disability Claim Service Center
P.O. Box 105426
Atlanta, GA 30348-5426
Phone: 800-232-0113
Fax: 800-850-0017
Email: disability@anthem.com