Short Term Disability Claim Form
Attending Physician Statement

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

Section 3: To be completed by the physician

Note to physician: Completion of this form will assist your patient in presenting claim for group and/or individual disability benefits. Please complete all areas of the form; if a section is non-applicable, please enter N/A in the response area.

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

Patient street address	City	State	ZIP code

Current diagnosis: _____

ICD10/DSM5: _____

Subjective complaints: _____

Objective findings: _____

Has patient ever had same or similar condition? ☐ Yes ☐ No If yes, specify dates of treatment: _____

Did injury or illness arise out of or in course of employment for wages or profit? ☐ Yes ☐ No ☐ Unknown
If yes, please explain: _____

Is disability due to pregnancy? ☐ Yes ☐ No EDC: _____ Type of delivery: ☐ Vaginal ☐ C-section

Was patient hospitalized? ☐ Yes ☐ No If yes, please provide date of confinement: _____
Name of hospital/facility: _____

Nature of surgical procedure, if any. Date performed: _____
Describe in full: _____

Date patient first unable to work	Date of first visit	Date of last visit	Date of next visit

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Other: _____

Treatment plan: _____

Functional impairments: _____

Current medications and dosages: _____

Patient released to return to work? ☐ Yes ☐ No
If yes: ☐ Full-time, no restrictions Date able to return to full duty: _____
☐ Light duty Date able to return to light duty: _____
Please specify restrictions, limitations, hours, graduated return to work schedule, etc.:
_____

Is this patient a suitable candidate for a rehabilitation program? ☐ Yes ☐ No

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

Printed physician name	Physician tax ID no.	Physician specialty

Physician street address	City	State	ZIP code

Physician phone no.	Physician fax no.	Physician email address

Physician signature **X**	Date (MMDDYYYY)