ATTENDING PHYSICIAN'S STATEMENT
LONG-TERM DISABILITY BENEFITS

MAIL FORM TO ⇒		National Insurance Company of Wisconsin, Inc. Attention: Claim Department 250 South Executive Drive–Suite 300, Brookfield, WI 53005-4273
CONTACT US ⇒		(800) 627-3660

Directions for completing this form: Please complete this form in its entirety. Failing to answer all questions may result in a delay of the processing of your patient's claim. Although we have tried to allow for a sufficient amount of space to answer each question, if you need more space, please attach a separate sheet of paper.

Please attach any pertinent medical records, office notes, test results, etc. to the completed form when returning to us.

Name of Patient: _____ Date of Birth: _____

Occupation: _____ Employer: _____

I. HISTORY

Are you this patient's regular physician? Yes ☐ No ☐ If no, by whom was this patient referred? _____

Patient's Height _____ Weight _____ Blood Pressure _____ Pulse (radial) _____

Patient's Dominant Hand: Right ☐ Left ☐

Date symptoms first appeared, or accident happened: ____/____/_____ Date of first visit to you for this condition: ____/____/_____

Date of most recent visit: ____/____/_____ Date of next visit: ____/____/_____

Frequency with which you see your patient: Weekly ☐ Monthly ☐ Other ☐ _____

Has your patient ever had the same or similar condition? Yes ☐ No ☐

If yes, indicate when and describe _____

_____

Are there other contributing conditions? Yes ☐ No ☐

If yes, please explain _____

_____

Is the condition primarily related to: (Check all that apply)

Work Related Injury ☐	Illness ☐	Alcohol or Drug Dependence ☐
Injury at home ☐	Mental Disorder ☐	Pregnancy ☐
Injury other than at work or home ☐	Motor Vehicle Accident ☐	

Name(s) and Address(es) of all other treating physicians: _____

_____

_____

_____

_____

II. DIAGNOSIS

Primary Diagnosis: _____

ICD (current version) Code: _____

Secondary Diagnosis: _____

ICD (current version) Code: _____

Patient's Name _____ **Date of Birth:** ____/____/_____
First **Middle** **Last**

Other Diagnoses and ICD (current version) Codes related to this claim: _____

_____

_____

_____

Subjective Symptoms: _____

_____

Objective Findings (include x-rays, EKG's, laboratory data, any clinical findings) **Please attach all relevant medical records to this form:**

_____

_____

III. TREATMENT PLAN

Planned course of treatment (please include expected duration, surgeries, therapy, etc.) _____

_____

_____

_____

Medications prescribed (dosage, frequency and date of prescriptions): _____

_____

Has your patient been referred to other doctors or therapy programs (P.T., O.T., psychotherapy)? Yes ☐ No ☐

If yes, please indicate to whom and dates: _____

_____

_____

If your patient is not working now, does the treatment plan include a definitive strategy for his/her return to work? Yes ☐ No ☐

If yes, please describe your return to work strategy _____

_____

_____

Have you had contact with the patient's employer regarding possible job modifications or a gradual return to work? Yes ☐ No ☐

If yes, please describe the return to work plan: _____

_____

_____

Is treatment complicated by any of the following? Please check all that apply, if any:

☐ Significant emotional or behavioral disorder such as depression or anxiety.
☐ Inconsistent findings, subjective complaints out of proportion to objective findings, contradictory observations.
☐ Dependence on drugs, alcohol, medication. Please explain: _____
☐ Other – please explain: _____

Is surgery planned? Yes ☐ No ☐

If yes, indicate procedure and anticipated date_____

If patient was hospitalized, please provide dates: Admitted ____/____/_____ Discharged ____/____/_____

Diagnosis: _____

ICD (current version) Code: _____

Name of Hospital: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Patient's Name _____ **Date of Birth:** ____/____/_____
First **Middle** **Last**

IV. ASSESSMENT

Describe your patient's condition since onset of symptoms: Recovered ☐ Improved ☐ Unchanged ☐ Regressed ☐

Has your patient reached maximum medical improvement? Yes ☐ No ☐

When do you expect a fundamental or marked change in his/her condition? Never ☐
Condition expected to regress ☐ OR
Condition expected to improve ☐

If condition is expected to improve, state anticipated date: ____/____/____ OR, Unable to determine, follow up in _____ months.

Is confinement to bed or home medically required? Yes ☐ No ☐

Please describe how your patient's condition affects his/her ability to work and also what activities the employee can do at work now based on your understanding of the patient's job duties: _____

_____

_____

Date you recommended your patient stop working? ____/____/_____ Why? _____

_____

Has your patient provided you with a self-report of his/her job tasks? Yes ☐ No ☐

Have you seen a job description? Yes ☐ No ☐

Based on your knowledge of your patient's job, what work modifications could the employer make to assist him/her to return to work?

_____

_____

If the patient's ability to perform any of the following activities is limited by his/her condition, please describe the extent of the limitations and the expected duration.

Standing: _____

Walking: _____

Sitting: _____

Lifting/carrying: _____

Reaching/working overhead: _____

Pushing: _____

Pulling: _____

Driving: _____

Keyboard use/repetitive hand motion: _____

If any other activities are limited, please specify the activities and the limitations: _____

_____

If the patient's vision is impaired, please describe the extent of the impairment: _____

_____

Describe your patient's mental and cognitive limitations as they relate to their work activities. What obstacles prevent a return to work?

_____

_____

_____

Patient's Name _____ **Date of Birth:** ____/____/_____
First **Middle** **Last**

Date you anticipate your patient can return to work:

Part-Time ____/____/_____

Full-Time ____/____/_____ OR

Unable to determine, due to:_____ Follow up in _____ months

Is your patient competent to endorse checks and direct the use of the proceeds thereof? Yes ☐ No ☐

Physician's Signature _____ Date: ____/____/_____

Physician's Name (please print or type) _____

Physician's Specialty/Degree(s) _____

Address _____ City _____ State _____ Zip Code _____

Telephone Number (_____)_____ Fax #: (_____)_____

Physician's Taxpayer ID Number: _____ E-mail Address: _____