Please fax the completed form to:
Fax Number: 833-357-5153
The Hartford
P.O. Box 14869 Lexington, KY 40512-4869
Email: GBInformationUpload@thehartford.com

Attending Physician's Statement – Initial

The patient is responsible for completing this form without expense to the company

Patient Last Name:	Patient First (or Preferred) Name:	Date of Birth:	Claim Id Number:

Condition

Patient's condition is a result of:
☐ Illness ☐ Injury
☐ Pregnancy

If illness or injury, is condition related to:
☐ Work Activity
☐ Motor Vehicle Accident
☐ Intentional/Self-Inflicted

If pregnancy, what is date of delivery?
__/__/____ (MM DD YYYY) ☐ Actual ☐ Estimated

Condition onset:
__/__/____ (MM DD YYYY)

First day recommended out of work:
__/__/____ (MM DD YYYY)

Projected return to work date:
__/__/____ (MM DD YYYY)

Office visit to complete this form:
__/__/____ (MM DD YYYY) ☐ In Person ☐ Telemedicine

Disabling Diagnosis(es) and Impact to Function

ICD 10 Codes
Please provide most specific codes:
___.____ / ___.____ / ___.____

Description of corresponding symptoms
_____
_____

Co-Morbid Conditions with Impact to Diagnosis

☐ None ☐ Opioid Usage ☐ Psoriasis ☐ Mental Health
☐ Diabetes ☐ Heart Disease ☐ Asthma/Bronchitis ☐ Cognitive Impairment
☐ Hypertension ☐ Obesity ☐ Auto-Immune Disease
☐ COPD ☐ Arthritis ☐ Other _____

In your opinion is the patient competent to endorse checks and direct the use of proceeds? ☐ Yes ☐ No

Treatment Plan

☐ Conservative treatment ☐ Bed Rest ☐ Palliative care ☐ Hospice Care

☐ Hospitalization Admittance date: __/__/____ (MM DD YYYY) Discharge date: __/__/____ (MM DD YYYY)

☐ Next/Another appointment Date: __/__/____ (MM DD YYYY) ☐ In Person ☐ Telemedicine

☐ Physical/Occupational therapy ____ times per ☐ week ☐ until __/__/____ (MM DD YYYY) ☐ Actual ☐ Estimated

☐ Surgery Date: __/__/____ (MM DD YYYY) CPT Code(s): _____ , _____

☐ Referral to a specialist Type: _____ Contact Info:_____

Current Medications (related to condition or impacting function)

☐ None ☐ Over counter medications: _____

☐ Prescription medications Name(s): _____

☐ Impacting function? ☐ Yes ☐ No If yes, why? _____

☐ Chemotherapy ☐ Radiation Start Date: __/__/____ (MM DD YYYY) End Date: __/__/____ (MM DD YYYY)

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Level of Functionality (Based upon your medical findings and opinion, address the full range of your patient's abilities. We will conclude that there are no restrictions on function unless specified below.)

In an 8-hour period the patient is able to: (select either Continuous or Intermittent)

	Continuously with standard breaks		Intermittently with standard breaks	If intermittent, circle time for each section below	
				Hours at one time	Total hours in 8 hours
Sit	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8
Stand	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8
Walk	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8

Expected duration of any restriction(s) or limitation(s) listed below THROUGH __/__/____
MM DD YYYY

Key: C = Continuously (5.5 – 8 hours) F = Frequently (2.5 – 5.5 hours) O = Occasionally (up to 2.5 hours) N = Never

Activity Ability	C	F	O	N	Activity Ability	Right/Left	C	F	O	N
☐ Drive	☐	☐	☐	☐	☐ Stoop/Squat		☐	☐	☐	☐
☐ Weight bearing	☐	☐	☐	☐	Hand Dominance	☐ R ☐ L				
☐ Climb	☐	☐	☐	☐	☐ Fine Manipulation	☐ R ☐ L	☐	☐	☐	☐
☐ Bend	☐	☐	☐	☐	☐ Reach above shoulder	☐ R ☐ L	☐	☐	☐	☐
☐ Max lift	☐ ____LBS	☐ ____LBS	☐ ____LBS	☐ ____LBS	☐ Reach below shoulder	☐ R ☐ L	☐	☐	☐	☐

Completed or Planned Diagnostic Tests, Labs and Imaging (related to the disabling diagnosis)

Completed: ☐ X-ray __/__/____ ☐ MRI __/__/____ ☐ CT __/__/____ ☐ EKG __/__/____
MM DD YYYY

☐ ECHO __/__/____ ☐ EMG __/__/____ ☐ Lab Work __/__/____

Findings of completed tests: ☐ No significant findings ☐ Confirmed diagnosis

Planned: ☐ X-ray ☐ MRI ☐ CT ☐ EKG ☐ ECHO ☐ EMG ☐ Lab Work Scheduled date __/__/____
MM DD YYYY

Provider Details

Provider Name: _____
Specialty: _____
EIN Number: _____
License Number: _____

Email: _____
Phone: (___)___-____
Fax: (___)___-____

Provider Signature: _____

Date: __/__/____
MM DD YYYY