

A MEMBER OF THE TOKIO MARINE GROUP

HEALTH CARE PROVIDER CERTIFICATION

[Please Fax Completed Form to Matrix Absence Management to (408) 361-9030

Dear Health Care Provider:

The purpose of this form is to help us determine whether the clinical condition of this patient is disabling. It is necessary for us to document functional impairment. Please complete the following report as completely as possible, and provide us copies of all objective data.

The asterisk questions must be completed to process benefits for your patient. GENERAL INFORMATION This claim is for (Patient's Name): Claim No: Employer: Last 4 digits of patient's social security number: Date of Birth (Month, Date, Year): TREATMENT INFORMATION Yes No Was the patient referred to you by another medical practitioner? If so, please furnish the name and telephone number: **Diagnosis: _____ ICD Codes Are there any concurrent disabling medical conditions? \square Yes \square No If yes, please explain: **For pregnancy **EDC:_____ Total number of visits: Date of initial visit: Date of last visit: ______Date of next visit: ______ **First Date Patient was unable to work _____ Anticipated Return to Work Date:____ **Objective/clinical findings - provide copies of test results and office notes that support findings: **Please explain the factors, which, in your opinion, prevent this patient from working: Is the patient's condition work related? \square Yes \square No If Yes, please explain: Have you filed a Doctor's Report of Injury? Yes No RETURN TO WORK **Work Status: Regular Work Release From: Part time Hours per Week or Day Modified Work Release From: _____ Through: _____ Hours Daily: _____

**The attached sheet provides the definition of a "serious health condition" under the Family and Medical Leave Act. Does the patient's condition qualify under any of the categories described? Yes No If yes, please check the applicable category: (1) (2) (3) (4) (5) (6)

From: _____ Through: _____ If no work, why? _____

Patient's Name:	

Discharged from Care Yes No If yes, date:

☐ No Work

WORK RESTRICTIONS:								
Check Appropriate Capabilities	No Restriction	Frequent 34-66% 4-7-9 hr. 200 reps/ day	Occasional 0-33% 0-3.9 hr. 32 reps/day	Seldom 0-6% 0-1 hr. 14 reps/day	Weight: 1-11 lbs.	Up to 20 lbs.	Up to 35 lbs.	Up to 50 lbs.
Lifting:								
Push/Pull: R L								
Sitting:								
Bending/Stooping:								
Climbing:								
Repetitive Work:								
Other: Restrictions								
Number of hours the patient I Date Patient may return to we Date you anticipate these co	ork with above n onditions may ch	oted conditions:			10 hours	12 hou	rs	
PATIENT TREATMENT P	LAN							
What is the treatment plan in	cluding prescrib	ed medications?						
Have you referred the patient	for other types o	f consultations or to	ests?	No If Yes, Exp	lain:			
Referred to:				Telephone:				
Type of Test:								
HEALTH CARE PROVIDI	ER COMPLETI	ES FOR ANY HOS	SPITAL CONFI	NEMENTS				
Name and address of hospital Date(s) treated from/to in the prior 2 years								
			F	ROM:		TO:		
			F	FROM:		TO:		
DATES OF IMPAIRMENT	AND DDOCN	OCIC EOD DECO	VEDV					
			VERY					
**What is your prognosis for	expected recover	y?						
**When do you expect Patient	t to be able to ret					fic date is		
Has your Patient achieved n	maximum medica			EAR	even	if it is an e	stimate ⁷⁷	
A person who knowingly file or deceive an insurance com indicated above, are true and	pany/administra	ator is committing	a fraudulent ins					
Physician's Name (PRINT):				Degree:		S	pecialty: _	_
Tax Identification No.:				Dr. License No.:				
Physician's Address:								
Celephone No.:				Fax No.:				
Physician's Signature:	ian's Signature: Date Signed:							

A structured Return to Work Program may be available for the injured/disabled employee during his/her medical recovery. Clear Return-to-Work restrictions will enable us to assist the Employee with a safe return to work. If you have questions or concerns, please contact Matrix Absence Management. Thank you for your cooperation. Return Completed Statement to:

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information,' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Definitions of "Serious Health Condition" for Medical and FMLA Certification

A "Serious Health Condition" means an illness, injury, impairment, or physical or mental condition that involves one of the following:

1. Hospital Care

Inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility, including any period of incapacity² or subsequent treatment in connection with or consequent to such inpatient care.

2. Absence Plus Treatment

A period of incapacity² of more than three consecutive calendar days (including any subsequent treatment or period of incapacity² relating to the same condition), that also involves:

- (1) Treatment³ two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services, e.g., physical therapist, under orders of, or on referral by, a health care provider; or
- (2) Treatment⁴ by a health care provider on at least one occasion which results in a regimen of continuing treatment⁴ under the supervision of the health care provider.

3. Pregnancy

Any period of incapacity due to pregnancy, or for prenatal care.

4. Chronic Conditions Requiring Treatments

A chronic condition which:

(1) Cause episodic rather than a continuing period of incapacity, e.g. asthma, diabetes, epilepsy, etc.

5. Permanent/Long Term Conditions Requiring Supervision

A period of incapacity, which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. Examples include Alzheimer's, a severe stroke, or the terminal stages of a disease.

6. Multiple Treatments (Non-Chronic Conditions)

Any period of absence to receive multiple treatments (including any period of recovery there from) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either of restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity' of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), kidney disease (dialysis)

PLOAFORM; forms generic and otherwise; generic serious health condition 112800

^{2.} "Incapacity", for purposes of FMLA, is defined to mean inability to work, attend school, or perform other regular daily activities due to the serious health condition, treatment therefore, or recovery there from.

³ Treatment includes examinations to determine if a serious health condition exists and evaluation of the condition. Treatment does not include routine physical examinations, eye examinations, or dental examinations.

⁴ A regimen of continuing treatment includes, for example, a course of prescription medication e.g., an antibiotic or therapy requiring special equipment to resolve or alleviate the health condition. A regimen of treatment does not include the taking of over-the-counter medication such as aspirin, antihistamines, or salves; or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.