CLAIM NUMBER: _____

Madison National Life

Insurance Company, Inc.
P.O. BOX 2865 CLINTON, IA 52733-2865
Telephone: 800-356-9601 Extension 2410 Fax: 608-830-2701

SUPPLEMENTAL ATTENDING PHYSICIAN'S STATEMENT

THIS IS A TIME SENSITIVE DOCUMENT

Thorough completion of this form will provide the information necessary to allow us to work closely with your patient and his/her employer to develop a plan which will promote a return to work. This form must be completed by a physician.

Name of patient:_____ DOB:_____ Telephone Number: _____

Address:_____
Street City State Zip

A. DIAGNOSIS / HISTORY

Current primary diagnosis:_____ ICD-9 code:_____
Current secondary diagnosis:_____ ICD-9 code:_____
Other diagnoses and ICD codes impacting this patient:_____

DSM IV Diagnosis (GAF): I._____ II._____
III._____ IV._____ V._____
Symptoms:_____

Date your patient can return to work: Part time:_____ Full time:_____
OR unable to determine due to:_____

Patient's Height: _____ Patient's Weight: _____ BP:_____ Patient's Dominant Hand: ☐ Right ☐ Left
Date current symptoms first appeared:_____ Date of most recent visit:_____
Date of next visit:_____

B. TREATMENT PLAN

Current planned course of treatment (please include expected duration, surgeries, therapy, etc.):_____

Treatment complicated by: ☐ Employer / Employee conflict ☐ Significant emotional or behavioral disorder ☐ Alcohol or Drug Dependence
☐MVA ☐Other :_____

Medications prescribed (dosage, frequency and date of prescriptions - (please feel free to use a separate sheet of paper)_____

Frequency with which you see your patient: ☐ Weekly ☐ Monthly ☐ PRN ☐ Other:_____
Has your patient been referred to other doctors or therapy programs (P.T., O.T., psychotherapy)? ☐ No ☐ Yes If yes, please indicate when and to whom:_____
If your patient is not working now, does the treatment plan include a definitive strategy for his/her return to work? ☐ No ☐ Yes
Have you had contact with the patient's employer regarding possible job modifications or gradual return to work? ☐ No ☐ Yes If yes, please describe the return to work plan:_____

C. HOSPITALIZATION / SURGERY

If patient was hospitalized within past year, please provide dates: Date of Admission:_____ Date of discharge:_____
Reason for admission or hospitalization:_____ ICD-9 code:_____
Name of hospital:_____ Name of doctor seen at hospital:_____
Address:_____
Street City State Zip Code
Was surgery performed? ☐ No ☐ Yes If yes, indicate procedure and date of surgery: _____
Is surgery planned? ☐ No ☐ Yes If yes, indicate planned procedure and anticipated date:_____

D. ASSESSMENT

Describe your patient's condition since onset of symptoms: ☐ Recovered ☐ Improved ☐ Unchanged ☐ Regressed
Has your patient reached optimum recovery? ☐ No ☐ Yes
If your patient has not reached optimum recovery, when do you expect a fundamental or marked change in his/her condition?
☐ Never ☐ Condition expected to regress ☐ Condition expected to improve, State anticipated date_____ ☐Unable to determine
Is confinement to bed or home medically required? ☐ No ☐ Yes If yes, please indicate duration of confinement. _____

Name of Patient:_____ Date of Birth_____

E. RESTRICTIONS AND LIMITATIONS

If physical or psychiatric limitations exist, how long do you feel that these limitations will last?_____

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

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

_____

Level of functional impairment:

What are your patient's physical restrictions and limitations? _____

In a typical work day, your patient can:

Lift (in pounds) ☐ 1 – 10 ☐ 11 – 20 ☐ 21 – 50 ☐ 51 – 75 ☐ 76+

Carry (in pounds) ☐ 1 – 10 ☐ 11 – 20 ☐ 21 – 50 ☐ 51 – 75 ☐ 76+

Bend/Stoop: ☐ Never ☐ Occasionally ☐ Frequently

If frequently, how frequently? _____

If allowed positional changes, patient can:

Sit: 8 7 6 5 4 3 2 1 0 (hrs)

Stand: 8 7 6 5 4 3 2 1 0 (hrs)

Walk: 8 7 6 5 4 3 2 1 0 (hrs)

Alternately sit/stand: 8 7 6 5 4 3 2 1 0 (hrs)

Number of days per week your patient can work:_____

Patient can work with arms in the following positions:

Right arm: Above shoulder ☐ No ☐ Yes Below shoulder ☐ No ☐ Yes At shoulder level ☐ No ☐ Yes

Left arm: Above shoulder ☐ No ☐ Yes Below shoulder ☐ No ☐ Yes At shoulder level ☐ No ☐ Yes

Patient can use arms/hands for repetitive action such as:

Right arm: Gross movements ☐ No ☐ Yes Pushing& pulling ☐ No ☐ Yes Fine movements ☐ No ☐ Yes

Left arm: Gross movements ☐ No ☐ Yes Pushing& pulling ☐ No ☐ Yes Fine movements ☐ No ☐ Yes

Patient can use his/her head and neck in:

Flexion ☐ Not at all ☐ Occasionally ☐ Frequently ☐ Continuously

Extension ☐ Not at all ☐ Occasionally ☐ Frequently ☐ Continuously

Rotation ☐ Not at all ☐ Occasionally ☐ Frequently ☐ Continuously

Is your patient able to drive: ☐ No ☐ Yes

Mental Impairment (if applicable)

Please define "stress" as it applies to this claimant: _____

What stress and problems in interpersonal relations has this claimant had on the 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).

What obstacles prevent a return to work?_____

Would you like assistance in developing a return to work plan? ☐ No ☐ Yes

Would you recommend vocational rehabilitation services (assignment of a case manager to assist your patient and the employer in return to work planning, or to provide assistance in a successful return to work)? ☐ No ☐ Yes

Comments:_____

_____

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

PLEASE READ CAREFULLY*************************************

MEDICAL RECORDS ARE REQUIRED IN ORDER FOR A PROPER REVIEW OF THIS CLAIM. WE ASK THAT YOU ATTACH COPIES OF LABORATORY DATA, RESULTS OF DIAGNOSTIC TESTS, OFFICE VISIT NOTES, PATIENT SURGICAL REPORTS, HOSPITALIZATION RECORDS, CHART NOTES AND NARRATIVE REPORTS FOR TREATMENT OCCURING WITHIN THE PAST SIX MONTHS. LACK OF MEDICAL RECORDS COULD RESULT IN A DELAY IN POSSIBLE PAYMENT OF BENEFITS.

The information I have provided on this form is accurate to the best of my knowledge.
I have received and read the fraud warning statements provided with this form.

Physician's signature:_____ Date:_____

Physicians name (please print):_____ Specialty:_____

Address:_____ City_____ State:_____ Zip code:_____

Phone number:_____ Medical record department fax number:_____

Fraud Warnings

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines, confinement in prison and/or denial of insurance benefits. This warning applies to the following states: Alabama, Alaska, Arkansas, Connecticut, Delaware, Hawaii, Idaho, Illinois, Indiana, Iowa, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, Virginia, West Virginia, Wisconsin, Wyoming.

ARIZONA WARNING: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

CALIFORNIA WARNING: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO WARNING: WARNING: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damage. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

DISTRICT OF COLUMBIA WARNING: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

FLORIDA WARNING: WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

GEORGIA WARNING: WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information, or, for the purpose of misleading, conceals information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

KANSAS WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of fraud, as determined by a court of law, and subject to fines, confinement in prison and/or denial of insurance benefits.

KENTUCKY WARNING: WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

LOUISIANA WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines, and confinement in prison.

MAINE WARNING: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MARYLAND WARNING: WARNING: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

NEW HAMPSHIRE WARNING: WARNING: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY WARNING: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW YORK WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

OREGON WARNING: WARNING: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer by submitting an application, or by filing a claim containing a false statement as to any material fact, may be violating state law.

PENNSYLVANIA WARNING: WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TENNESSEE WARNING: WARNING: It is a crime to knowingly supply false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

WASHINGTON WARNING: WARNING: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Signature: _____ Date: _____