Clear form

FC 21

Attending Physician's Statement

Minnesota Life Insurance Company - A Securian Company
Claims • P.O. Box 64114 • St. Paul, MN 55164-0114

For claim information call:
1-888-658-0193
Fax: 651-665-7106

MINNESOTA LIFE

- ☐ Please have this form completed immediately.
- ☐ Please have this form completed on or after _____ .
- ☐ Please have this form completed on _____ or upon recovery if sooner.
- ☐ If you remain disabled beyond _____ and wish further consideration of your claim, please have this completed on _____ or upon recovery if sooner.

CLAIM NUMBER:

The insured is responsible for the completion of this form without expense to the Company. Both sides of this form must be fully completed by the attending physician.

Patient's name			Telephone number
Date of birth (mo/day/yr)	Height	Weight	Blood pressure reading/date

HISTORY

1. Date symptoms first appeared or accident occurred	2. Date patient ceased work due to disability	3. Is condition due to injury or illness arising out of patient's employment? If yes, check one. ☐ Yes ☐ No ☐ Injury ☐ Illness

4. Has patient ever had same or similar condition? If yes, state when and describe.
☐ Yes ☐ No

5. Names and addresses of other treating physicians

DIAGNOSIS

1. Diagnosis including any complications for current condition	2. Patient account/file number

3. Subjective symptoms

4. Objective findings (including current x-rays, EKG's, laboratory data and any clinical findings)

NATURE AND DATES OF SERVICE

1. Date (mo/day/yr) of first visit	2. Date (mo/day/yr) of last visit	3. Date (mo/day/yr) of next visit	4. Frequency

5. Has patient been hospitalized? If yes, give dates.
☐ Yes ☐ No From _____ through _____

6. Was surgery performed? If yes, state when and describe.
☐ Yes ☐ No

7. Name and address of hospital

8. Is the patient currently enrolled in any type of rehabilitation program? ☐ Yes ☐ No

9. If yes, what type of program? ☐ Cardiac ☐ Physical therapy ☐ Other _____

10. List medications

CLAIM NUMBER:

CARDIAC Functional capacity (American Heart Association)

☐ CLASS 1 (No limitation) ☐ CLASS 2 (Slight limitation) ☐ CLASS 3 (Marked limitation) ☐ CLASS 4 (Complete limitation)

1. Describe the basis for above classification

PHYSICAL IMPAIRMENT (*as defined in Federal Dictionary of Occupational Titles)

☐ Class 1 – No limitation of functional capacity; capable of heavy work. *No restrictions (0 - 10%).
☐ Class 2 – Medium manual activity* (15 - 30%).
☐ Class 3 – Slight limitation of functional capacity; capable of light work* (35 - 55%).
☐ Class 4 – Moderate limitation of functional capacity; capable of clerical/administration (sedentary*) activity (60 - 70%).
☐ Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary*) activity (75 - 100%).

1. List all restrictions and describe the basis for above classification

MENTAL/NERVOUS IMPAIRMENT

☐ 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 limitation).
☐ Class 5 – Patient has significant loss of psychological, personal and social adjustment (severe limitations).

1. Describe the basis for above classification

2. Do you feel this patient is competent to endorse and direct the use of proceeds thereof?
☐ Yes ☐ No

PROGRESS

1. Patient has . . . (check all that apply) ☐ Recovered ☐ Improved ☐ Unchanged ☐ Retrogressed ☐ Reached maximum medical improvement - impairment rating of _____ %

2. If recovered, date (mo/day/yr) released to return to work.

3. Patient is . . . (check one) ☐ Ambulatory ☐ Bed Confined ☐ House Confined ☐ Hospital Confined

4. Patient is a suitable candidate for ☐ Trial employment ☐ Full-time ☐ Part-time ☐ Work hardening ☐ Job retraining

PROGNOSIS	REGULAR WORK	OTHER WORK
1. Is patient now totally disabled?.....	☐ Yes ☐ No If no, date released _____	☐ Yes ☐ No If no, date released _____
2. Do you expect a change in the future relating to patient's ability to work?.....	☐ Yes - Improvement ☐ Yes - Deterioration ☐ No	☐ Yes - Improvement ☐ Yes - Deterioration ☐ No
a) If improvement is expected, when will patient recover sufficiently to perform duties?.....	☐ 1 Mo ☐ 4-6 Mo ☐ Never ☐ 2-3 Mo ☐ Other _____	☐ 1 Mo ☐ 4-6 Mo ☐ Never ☐ 2-3 Mo ☐ Other _____

b) If no, please explain.

Remarks

Have you provided information for this patient for another insurance company or agency?
☐ Yes ☐ No If yes, list company/agency name, telephone number and claim number.

Name of attending physician (please print)	Degree	Telephone number

Physician's address (street, city, state, zip)

Signature of attending physician	Date signed	Print name of person completing this form
X		

For your protection, state laws require 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. Any insurance company or agent of an insurance company who knowingly attempts to defraud a policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Division of Insurance.

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