Attending Physician's Statement

Administered by
Principal Life Insurance Company
Attn: Group Life and Disability Claims Department
Des Moines, Iowa 50392-0002
Toll free Nationwide 800-245-1522
Toll free fax 800-255-6609
Email: SBDClaims@principal.com

Principal®

Attending Physician Statement - To be completed by your Physician – Include office notes and test results from date of disability to present

The following information is needed to document the patient's inability to work. The patient is responsible for obtaining a complete form without expense to Principal. Please complete this form and mail or fax it to Principal using the contact information listed above.

1 Patients Name: | Date of Birth: / /

2 Social Security #: | Height: | Weight:

3 Patient is/was unable to work due to : Injury ☐ Illness ☐ Pregnancy ☐ | **If pregnancy,** Skip to question 19

4 List all ICD-10 Diagnosis Code(s):

5 List any complications your patient is experiencing:

6 Objective Findings **(X-rays, EKG's, MRI results, lab data and clinical findings)**

7 Subjective Symptoms

8 Please provide date symptoms first appeared or accident happened? / /

9 Is the condition due to injury or illness arising from of your patient's employment? Yes ☐ No ☐

10 Did this condition already exist and become exacerbated by employment? Yes ☐ No ☐

If yes, please explain:

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

12 Date of first visit / /	**13** Date of last visit / /	**14** Date of next visit / /	**15** Frequency of visits

16 Has your patient been hospitalized? Yes ☐ No ☐ If Yes, From date: / / To date: / /

Hospital Name: Phone Number:

17 Has your patient ever had the same or similar condition? Yes ☐ No ☐ **If yes**, when / /

18 **NATURE OF TREATMENT – Please specify all surgeries, medications AND dosage, therapy, and/or referrals.**

Date of Surgery / / Type of surgery CPT-4 Codes

If the patient was referred to you or by you to another physician list the Physician's name, address and phone number of the Physician:

19 **PREGNANCY SUBMISSIONS ONLY**

What is the expected date of delivery? / /	Date first treated / /	Date last treated / /	Date of delivery / /

Bed confined? Yes ☐ No ☐ **If yes**, Date From: / / To: / / Type of delivery: Vaginal ☐ C-Section ☐

If complications are present prior to delivery, what complications is your patient experiencing?

20 PHYSICAL IMPAIRMENT

After discussing job duties with your patient, please provide the specific restrictions and limitations you have placed on your patient in the space provided below:

	CONTINUOUSLY (2/3 + of time)	FREQUENTLY (1/3 – 2/3 of time	OCCASIONALLY (Up to 1/3 of time)	NEVER
Sit	☐	☐	☐	☐
Stand	☐	☐	☐	☐
Walk	☐	☐	☐	☐
Lift/Carry	lbs.	lbs.	lbs.	lbs.
Power Grasp	☐	☐	☐	☐
Fine Manipulation	☐	☐	☐	☐
Push/Pull	☐	☐	☐	☐
Keyboarding	☐	☐	☐	☐
Reach above shoulder level	☐	☐	☐	☐
Reach at waist level/below waist	☐	☐	☐	☐
Bend/Twist/Squat	☐	☐	☐	☐
Climb/Balance	☐	☐	☐	☐

21 PROGNOSIS:

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

How long do you expect these limitations and restrictions to impair your patient? ☐ Date: ____/____/_____ ☐Permanently

☐ Unable to determine, follow-up in _____weeks Do you support return to work with the limitations listed above at this time? Yes ☐ No ☐

Do you support return to work on a part time basis? Yes ☐ No ☐ If yes, how many hours per day?

22 Physician Name (Please Print) _____ Degree _____

Specialty _____ Phone Number _____ FAX Number _____

Address _____ City _____ State _____ Zip Code _____

Tax ID Number: NPI Number:

I certify the answers I have made to the above questions are complete and true to the best of my knowledge and belief.

Signature (No Stamp) X Date: / /

