

Health Care Provider Statement (HCPS)

To be completed by a treating health care provider.

A. PATIENT INFORMATION		
1. Name of Patient	Date of Birth	SSN
2. Date of First Visit	Date of Last Visit	Date of Next Visit
B. MEDICAL HISTORY		
3. Primary Diagnosis	ICD 9	GAF
4. Secondary Diagnosis	ICD 9	GAF
5. Subjective Symptoms	When did symptoms first appear?	
6. Objective Findings (including diagnostic tests, laboratory or clinical findings)		
7. Treatment plan, medications, and duration of treatment		
8. If referring to another physician, please provide name and specialty		
C. HOSPITALIZATIONS and SURGICAL PROCEDURES		
9. Name of Hospital	Date of Admission	Date of Discharge
10. Reason for Hospitalization		
11. Surgical Procedure, if applicable	Date Performed/Scheduled	CPT Procedure Code
D. PROGNOSIS and RETURN TO WORK		
12. What is the medical prognosis? Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor <input type="checkbox"/> Guarded <input type="checkbox"/>		
13. Has patient reached Maximum Medical Improvement (MMI)? Yes <input type="checkbox"/> No <input type="checkbox"/>		If no, estimated MMI date?
14. Has disability lasted, or is it expected to last, for a continuous period of not less than 12 months? Yes <input type="checkbox"/> No <input type="checkbox"/>		Is disability expected to result in death? Yes <input type="checkbox"/> No <input type="checkbox"/>
15. On what objective evidence do you base your response to question 14?		
16. What type of activities can patient do over the course of a day? Please describe with regard to functional capability for activities of daily living (ADL), such as cooking, household chores, shopping, etc., as defined by the Social Security Administration.		
17. Can periodic exacerbations of this condition be expected? Yes <input type="checkbox"/> No <input type="checkbox"/> Is it medically necessary for the patient to be absent from work during these exacerbations? Yes <input type="checkbox"/> No <input type="checkbox"/>		
18. Do you believe that the patient is competent to endorse checks and direct the use of the proceeds thereof? Yes <input type="checkbox"/> No <input type="checkbox"/>		
19. Please check one: <input type="checkbox"/> Patient is capable of returning to work with no restrictions effective _____. <input type="checkbox"/> Estimated return to work with no restrictions effective _____. <input type="checkbox"/> Estimated return to work with restrictions . Please indicate limitations on the attached Functional Abilities Form (FAF). <input type="checkbox"/> Patient is unable to return to work at this time. Please indicate limitation on the attached Functional Abilities Form (FAF).		
E. PHYSICIAN'S INFORMATION		
Physician's Name (please print):	Physician's Signature:	Date:
		Email:
Degree/Specialty:	Address:	Phone:
		Fax: