Renaissance®
DENTAL • VISION • LIFE • DISABILITY

GROUP DISABILITY CLAIM FORM
PHYSICIAN STATEMENT

-Please Print or Type in Dark Ink-

INSTRUCTIONS:

This claim application requests information that is necessary for the quick and accurate administration of your patient's disability claim. If the claim application is not completed in full, determination will be delayed until all required information has been received. If a question does not apply, or information is not available, please write "NA" (Not Applicable) in those spaces.

SEND COMPLETED FORMS TO:

- **MAIL:** 2 Court St. Suite 102, Binghamton, NY 13901
- **SECURE EMAIL:** GroupClaims@RenaissanceFamily.com
- **SECURE FAX TO:** 607-773-2276

FOR QUESTIONS CALL US AT: 844-368-6485

PHYSICIAN, PHYSICIAN ASSISTANT, NURSE PRACTITIONER STATEMENT

Patient Name *(Last, First, MI)*:		**Date of Birth** *(mm/dd/yyyy)*:	
Height:	**Weight:**	**Blood Pressure** *(Last Visit)*:	
Patient Is/Was Unable to Work Due To *(Check One)*: Injury Illness Pregnancy			
Diagnosis *(Include Complications and ICD 10)*:			

FOR NORMAL PREGNANCY, COMPLETE THE FOLLOWING ITEMS, THEN SKIP TO PAGE TWO:

LMP Date *(mm/dd/yyyy)*:	**EXP. Date of Delivery** *(mm/dd/yyyy)*:	**Date First Treated** *(mm/dd/yyyy)*:	**Date Last Treated** *(mm/dd/yyyy)*:
Date You Advised Patient to Stop Working *(mm/dd/yyyy)*:			

FOR ALL CONDITIONS EXCEPT NORMAL PREGNANCY, COMPLETE THE FOLLOWING ITEMS

When Did Symptoms First Appear or Accident Happen *(mm/dd/yyyy)***?:**	**Is Condition Due to Injury or Illness Arising Out of Patient's Employment?:** Yes No
Has Patient Ever Had Same or Similar Condition?: Yes No *(If Yes, State When and Describe)*:	

PHYSICIAN, PHYSICIAN ASSISTANT, NURSE PRACTITIONER STATEMENT (CONTINUED)

Date of First Visit *(mm/dd/yyyy)* :	**Date Last Visit** *(mm/dd/yyyy)*:	**Frequency of Visits:**

Objective Findings *(X-Rays, EKG's, Lab Data and Clinical Findings)*:	**Subjective Symptoms:**

Nature of Treatment *(Surgery, Medications, Etc.)* **Provide Medication Dosage and Frequency:**

Names and Addresses of Other Physicians:

Has Patient Been Hospitalized?: Yes No **If Yes, Give Name and Address:**	**From** *(mm/dd/yyyy)*: _____ **To** *(mm/dd/yyyy)*: _____

Restrictions *(What the Patient **SHOULD NOT** Do)*:	**Limitations** *(What the Patient **CANNOT** Do)*:

Mental Impairment (If Applicable) Provide DSM-5 AXIS Diagnosis:

1. _____
2. _____
3. _____
4. _____
5. _____

If This is a Cardiac Condition, What is the Functional Capacity? *(American Heart Association)*

Class 1—No Limitation Class 2—Slight Limitation Class 3—Marked Limitation Class 4—Complete Limitation

Has Maximum Medical Improvement Been Achieved?: Yes No **If No, When Do you Expect a Fundamental Change:**

1-2 Weeks 3-4 Weeks 5-6 Weeks More than 6 Weeks

If Employer Can Accommodate Patient's Limitations and Restrictions, Is Patient Able to Return to Work?: Yes No

If Yes, What Date Could Employment Begin *(mm/dd/yyyy)?*:

Print Name *(Last, First, MI)*:		**Lic. Number:**	
Specialty:	**Phone:**	**Tax ID:**	
Address *(Include Apt#/Suite)*:	**City:**	**State:**	**ZIP Code:**

X _____ _____

Physician or Health Care Provider Signature *(Required) (No Stamp)* **Date Signed** *(mm/dd/yyyy)*

—State Fraud Warnings on Following Pages—

LIFE AND DISABILITY STATE FRAUD WARNING STATEMENTS:

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW. PLEASE SEE BELOW FOR STATE-SPECIFIC VARIATIONS OF THIS FRAUD NOTICE.

CALIFORNIA: WARNING: FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT INFORMATION TO OBTAIN OR AMEND INSURANCE COVERAGE OR TO MAKE A CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

FLORIDA: 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.

NEW YORK (EXCLUDING LIFE INSURANCE): 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 FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Renaissance®
DENTAL • VISION • LIFE • DISABILITY