Please fax the completed form to:
Fax Number: 833-357-5153
The Hartford
P.O. Box 14869
Lexington, KY 40512-4869
Email: GBInformationUpload@thehartford.com

Clear Form

Attending Physician's Statement – Initial

To be completed by the Provider (The patient is responsible for any expense related to the completion of this form)

Patient Last Name:	Patient First (or Preferred) Name:	Date of Birth:	Claim Id Number:

Condition

Patient's condition is a result of:
☐ Illness ☐ Injury
☐ Pregnancy

If illness or injury, is condition related to:
☐ Work Activity ☐ Motor Vehicle Accident
☐ Intentional/Self-Inflicted

If pregnancy, what is date of delivery?
__/__/____ (MM DD YYYY) ☐ Actual ☐ Estimated

Condition onset: __/__/____ (MM DD YYYY)

Date you first treated this patient: __/__/____ (MM DD YYYY)

First day recommended out of work:
__/__/____ (MM DD YYYY)

Office visit to complete this form:
__/__/____ (MM DD YYYY) ☐ In Person ☐ Telemedicine

Projected return to work date:
__/__/____ (MM DD YYYY)

Disabling Diagnosis(es) and Impact to Function

ICD-10 Code
Please provide most specific codes:

|__||__||__|.|__||__||__||__| and |__||__||__|.|__||__||__||__|

Description of corresponding symptoms

Please provide most specific code possible, one character per block, up to two code entries possible. Ex.: |X|#|#|.|#|#|#|#|

Co-Morbid Conditions with Impact to Diagnosis

☐ None ☐ Opioid Usage ☐ Psoriasis ☐ Mental Health
☐ Diabetes ☐ Heart Disease ☐ Asthma/Bronchitis ☐ Cognitive Impairment
☐ Hypertension ☐ Obesity ☐ Auto-Immune Disease
☐ COPD ☐ Arthritis ☐ Other _____

In your opinion is the patient competent to endorse checks and direct the use of proceeds? ☐ Yes ☐ No

Treatment Plan

☐ Conservative treatment ☐ Bed Rest ☐ Palliative care ☐ Hospice Care

☐ Hospitalization Admittance date: __/__/____ (MM DD YYYY) Discharge date: __/__/____ (MM DD YYYY)

☐ Next/Another appointment Date: __/__/____ (MM DD YYYY) ☐ In Person ☐ Telemedicine

☐ Physical/Occupational therapy |__| times per week ☐ until __/__/____ (MM DD YYYY) ☐ Actual ☐ Estimated

☐ Surgery Date: __/__/____ (MM DD YYYY) CPT Code(s): |__||__||__||__||__| and |__||__||__||__||__|
Please provide most specific code possible, one number per block, up to two code entries possible. Ex.: |#|#|#|#|#|

☐ Referral to a specialist Type: _____ Contact Info: _____

Current Medications (related to condition or impacting function)

☐ None ☐ Over counter medications: _____

☐ Prescription medications Name(s): _____

☐ Impacting function? ☐ Yes ☐ No If yes, why? _____

☐ Chemotherapy ☐ Radiation Start Date: __/__/____ (MM DD YYYY) End Date: __/__/____ (MM DD YYYY)

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Level of Functionality (Based upon your medical findings and opinion, address the full range of your patient's abilities. We will conclude that there are no restrictions on function unless specified below.)

Expected duration of any restriction(s) or limitation(s) listed below THROUGH __/__/____ (MM/DD/YYYY)

In a workday the patient is able to: (select either Continuous or Intermittent)

	Continuously with standard breaks		Intermittently with standard breaks	If intermittent, enter time for each section below	
				Hours at one time	Total hours in a workday
Sit	☐	or	☐	|___|	|___|
Stand	☐	or	☐	|___|	|___|
Walk	☐	or	☐	|___|	|___|

Key: C = Continuously (5.5 – 8 hours) F = Frequently (2.5 – 5.5 hours) O = Occasionally (up to 2.5 hours) N = Never

Activity Ability	C	F	O	N	Activity Ability	Right/Left	C	F	O	N
☐ Drive	☐	☐	☐	☐	☐ Squat / Kneel		☐	☐	☐	☐
☐ Weight bearing	☐	☐	☐	☐	Hand Dominance	☐ R ☐ L				
☐ Climb	☐	☐	☐	☐	☐ Fine Manipulation	☐ R ☐ L	☐	☐	☐	☐
☐ Bend	☐	☐	☐	☐	☐ Gross Manipulation	☐ R ☐ L	☐	☐	☐	☐
☐ Max lift	____LBS	____LBS	____LBS	____LBS	☐ Reach above shoulder	☐ R ☐ L	☐	☐	☐	☐
☐ Max Carry	____LBS	____LBS	____LBS	____LBS	☐ Reach below shoulder	☐ R ☐ L	☐	☐	☐	☐

Completed or Planned Diagnostic Tests, Labs and Imaging (related to the disabling diagnosis)

Completed: ☐ X-ray __/__/____ (MM/DD/YYYY) ☐ MRI __/__/____ ☐ CT __/__/____ ☐ EKG __/__/____

☐ ECHO __/__/____ ☐ EMG __/__/____ ☐ Lab Work __/__/____

Findings of completed tests: ☐ No significant findings ☐ Confirmed diagnosis

Planned: ☐ X-ray ☐ MRI ☐ CT ☐ EKG ☐ ECHO ☐ EMG ☐ Lab Work Scheduled date __/__/____ (MM/DD/YYYY)

Provider Details

Provider Name: _____
Specialty: _____
EIN Number: _____
License Number: _____

Email: _____
Phone: (___) ___-____
Fax: (___) ___-____

Provider Signature: _____

Date: __/__/____ (MM/DD/YYYY)