

# Attending Physician's Statement – Progress Report

The patient is responsible for completion of this form without expense to the company

Patient Last Name:	Patient First (or Preferred) Name:	Date of Birth:	Claim Id Number:
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## Condition Please complete this form based upon the most recent patient contact/evaluation

Projected full time return to work date: __/__/____ MM DD YYYY	Office visit to complete this form: __/__/____ MM DD YYYY <div style="display: flex; justify-content: space-between;"> <input type="checkbox"/> In Person           <input type="checkbox"/> Telemedicine         </div>	If pregnancy, what is date of delivery? __/__/____ MM DD YYYY <div style="display: flex; justify-content: space-between;"> <input type="checkbox"/> Actual           <input type="checkbox"/> Estimated         </div>
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## Current Disabling Diagnosis(es) and Impact to Function

ICD 10 Codes Please provide most specific codes:   _ _ _ _ _ _ _ _ _ _  \  _ _ _ _ _ _ _ _ _ _	Description of corresponding symptoms and clinical exam findings:  _____ _____
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## Co-Morbid Conditions with Impact to Diagnosis

<input type="checkbox"/> None	<input type="checkbox"/> Opioid Usage	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Mental Health
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Asthma/Bronchitis	<input type="checkbox"/> Cognitive Impairment
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Obesity	<input type="checkbox"/> Auto-Immune Disease	In your opinion is the patient competent to endorse checks and direct the use of proceeds? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> COPD	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Other _____	

## Treatment Plan

<input type="checkbox"/> Conservative treatment	<input type="checkbox"/> Bed Rest	<input type="checkbox"/> Palliative care	<input type="checkbox"/> Hospice Care
<input type="checkbox"/> Hospitalization	Admittance date: __/__/____ MM DD YYYY		Discharge date: __/__/____ MM DD YYYY
<input type="checkbox"/> Next/Another appointment	Date: __/__/____ MM DD YYYY	<input type="checkbox"/> In Person	<input type="checkbox"/> Telemedicine
<input type="checkbox"/> Physical/Occupational therapy	_  times per week	<input type="checkbox"/> until __/__/____ MM DD YYYY	<input type="checkbox"/> Actual <input type="checkbox"/> Estimated
<input type="checkbox"/> Surgery	Date: __/__/____ MM DD YYYY	CPT Code(s):  _ _ _ _ _ _ _ _ _ _  \  _ _ _ _ _ _ _ _ _ _	
<input type="checkbox"/> Referral to a specialist Type: _____ Contact Info: _____			

## Current Medications (related to condition or impacting function)

<input type="checkbox"/> None	<input type="checkbox"/> Over counter medications: _____
<input type="checkbox"/> Prescription medications	Name(s): _____
<input type="checkbox"/> Impacting function?	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, why? _____
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> 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	<input type="checkbox"/>	or <input type="checkbox"/>	__	__
Stand	<input type="checkbox"/>	or <input type="checkbox"/>	__	__
Walk	<input type="checkbox"/>	or <input type="checkbox"/>	__	__

**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
<input type="checkbox"/> Drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Squat/Kneel		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Weight bearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hand Dominance	<input type="checkbox"/> R <input type="checkbox"/> L				
<input type="checkbox"/> Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Fine Manipulation	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Gross Manipulation	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Max lift	____LBS	____LBS	____LBS	____LBS	<input type="checkbox"/> Reach above shoulder	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Max carry	____LBS	____LBS	____LBS	____LBS	<input type="checkbox"/> Reach below shoulder	<input type="checkbox"/> R <input type="checkbox"/> L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

**Completed:** ☐ X-ray \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
MM DD YYYY ☐ MRI \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
MM DD YYYY ☐ CT \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
MM DD YYYY ☐ EKG \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
MM DD YYYY ☐ ECHO \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
MM DD YYYY ☐ EMG \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
MM DD YYYY ☐ Lab Work \_\_\_\_/\_\_\_\_/\_\_\_\_\_  
MM DD YYYY

**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