bac

ATTENDING PHYSICIAN'S STATEMENT OF DISABILITY

INSTRUCTIONS: COMPLETE THIS FORM AND RETURN TO THE ADMINISTRATION DEPARTMENT AT BAC, PO BOX 107, REYNOLDSBURG, OH 43068-0107.

THE PATIENT IS RESPONSIBLE FOR THE COMPLETION OF THIS FORM WITHOUT EXPENSE TO: BUSINESS ADMINISTRATORS & CONSULTANTS, INC. (BAC)

A. GENERAL INFORMATION & AUTHORIZATION: PLEASE PRINT

TO BE COMPLETED BY PATIENT OR GAURDIAN

EMPLOYER'S NAME:

I.D. NUMBER:

PATIENT'S NAME:

DATE OF BIRTH (MM/DD/YYYY):

PATIENT'S ADDRESS: CITY: STATE: ZIP CODE:

I AUTHORIZE ANY PROVIDER OF MEDICAL SERVICES, INSURANCE COMPANY, CONSUMER REPORTING AGENCY, SOCIAL SECURITY ADMINISTRATION, OR EMPLOYER, HAVING MEDICAL INFORMATION WITH RESPECT TO ANY PHYSICAL OR MENTAL CONDITION AND OTHER NON-MEDICAL INFORMATION REGARDING ME TO GIVE TO BUSINESS ADMINISTRATORS & CONSULTANTS, INC., OR ITS REPRESENTATIVE, ANY AND ALL SUCH INFORMATION. I UNDERSTAND THE INFORMATION OBTAINED BY USE OF THIS AUTHORIZATION WILL BE USED BY BUSINESS ADMINISTRATORS & CONSULTANTS, INC. TO DETERMINE ELIGIBILITY FOR INSURANCE BENEFITS. I KNOW THAT A PHOTOGRAPHIC COPY OF THIS AUTHORIZATION SHALL BE AS VALID AS THE ORIGINAL. I AGREE THIS AUTHORIZATION SHALL BE VALID FOR THE DURATION OF THE CLAIM.

X _____ _____

SIGNATURE OF INSURED (NOT VALID UNLESS SIGNED IN INK): **DATE SIGNED** (MM/DD/YYYY):

EMPLOYEE'S ADDRESS (IF DIFFERENT): CITY: STATE: ZIP CODE:

B. ATTENDING PHYSICIANS STATEMENT: PLEASE PRINT

1. HISTORY:

WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN? (MM/DD/YYYY):

ON WHAT DAY DO YOU FEEL THE CLAIMANT WAS FIRST UNABLE TO WORK, OR TOTALLY DISABLED FROM ANY GAINFUL EMPLOYMENT FOR WHICH HE/SHE IS REASONABLY SUITED?

HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?
◯ **YES** ◯ **NO**

IF YES TO SAME CONDITION, ADD A SHORT DESCRIPTION & DATES:

IS CONDITION DUE TO INJURY OR SICKNESS ARISING OUT OF PATIENT'S EMPLOYMENT?
◯ **YES** ◯ **NO** ◯ **UNKNOWN**

IF RESULT OF AUTO ACCIDENT:
STATE OF OCCURANCE:

NAMES AND ADDRESSES OF OTHER TREATING PHYSICIANS:

2. DIAGNOSIS (INCLUDING ANY COMPLICATIONS):

LAST EXAMINATION (MM/DD/YYYY):

SUBJECTIVE SYMPTOMS:

OBJECTIVE FINDINGS (INCLUDING CURRENT X-RAYS, EKG'S, LABORATORY DATA AND ANY CLINICAL FINDINGS):

IF DISABILITY IS DUE TO PREGNANCY, WHAT IS/WAS THE EXPECTED DELIVERY DATE:

LIST COMPLICATIONS THAT WOULD EXTEND THIS DISABILITY LONGER THAN A NORMAL PREGNANCY:

ATTENDING PHYSICIANS STATEMENT CONTINUES ON BACK

B. ATTENDING PHYSICIANS STATEMENT: CONTINUED...

3. DATES OF TREATMENT:

FIRST VISIT (MM/DD/YYYY):	LAST VISIT (MM/DD/YYYY):	FREQUENCY:
		◯ **WEEKLY** ◯ **MONTHLY** ◯ **OTHER** (SPECIFY):

4. NATURE OF TREATMENT (INCLUDING SURGERY AND MEDICATIONS PRESCRIBED, IF ANY):

5. DO YOU BELIEVE THE PATIENT IS COMPETENT TO ENDORSE CHECKS AND DIRECT THE USE OF THE PROCEEDS THERE OF?:

◯ **YES** ◯ **NO**

6. CARDIAC (IF APPLICABLE):

FUNCTIONAL CAPACITY (AMERICAN HEART ASSOCIATION):	BLOOD PRESSURE (LAST VISIT):
◯ **CLASS 1 (NO LIMITATION)** ◯ **CLASS 2 (SLIGHT LIMITATION)**	**SYSTOLIC:**
◯ **CLASS 3 (MARKED LIMITATION)** ◯ **CLASS 4 (COMPLETE LIMITATION)**	**DIASTOLIC:**

7. PHYSICAL IMPAIRMENT (*AS DEFINED IN FEDERAL DICTIONARY OF OCCUPATIONAL TITLES):

◯ **Class 1 – No Limitation of functional capacity: capable of heavy work*** **No restrictions** **(0 - 10%)**
◯ **Class 2 – Medium manual activity*** **(15 - 30%)**
◯ **Class 3 – Slight limitation of functional capacity; capable of light work*** **(35 - 55%)**
◯ **Class 4 – Moderate limitation of functional capacity of clerical/administrative (sedentary*) activity** **(60 - 70%)**
◯ **Class 5 – Severe limitation of functional capacity; incapable of minimal (sedentary*) activity** **(75 - 100%)**
◯ **Remarks:**

8. MENTAL/NERVOUS IMPAIRMENT (IF APPLICABLE):

◯ **Class 1 – Patient is able to function under stress situations and engage in interpersonal relations** **(No Limitations)**
◯ **Class 2 – Patient is able to function in most stress situations and engage in only limited interpersonal relations** **(Slight Limitations)**
◯ **Class 3 – Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations** **(Moderate Limitations)**
◯ **Class 4 – Patient is unable to engage in stress situations or engage in interpersonal relations** **(Marked Limitations)**
◯ **Class 5 – Patient has significant loss of psychological, physiological, personal and social adjustment** **(Severe Limitations)**
◯ **Remarks:**

PLEASE DEFINE "STRESS" AS IT APPLIES TO THIS CLAIMANT

WHAT STRESS AND PROBLEMS IN INTERPERSONAL RELATIONS HAS CLAIMANT HAD?

9. PROGRESS:

HAS PATIENT:	IS PATIENT:
◯ **RECOVERED** ◯ **IMPROVED** ◯ **UNCHANGED** ◯ **RETROGRESSED**	◯ **AMBULATORY** ◯ **HOUSE CONFINED** ◯ **BED CONFINED** ◯ **HOSPITAL CONFINED**

HAS PATIENT BEEN HOSPITAL CONFINED?	DATES OF CONFINEMENT:
◯ **YES, GIVE NAME & ADDRESS OF HOSPITAL:**	**FROM:**
◯ **NO**	**THROUGH:**

10. PROGNOSIS:

IS PATIENT NOW TOTALLY DISABLED FROM ANY GAINFUL EMPLOYMENT FOR WHICH HE/SHE IS REASONABLY SUITED?

◯ **YES** ◯ **NO**

IF NOT TOTALLY DISABLED, WHAT WERE THE INCLUSIVE DATES OF DISABILITY? (MM/DD/YYYY):

IF NOT NOW TOTALLY DISABLED, WHEN WAS PATIENT ABLE TO RESUME WORK?

◯ **FULL-TIME (MM/DD/YYYY):** ◯ **PART-TIME (MM/DD/YYYY):**

WHAT DUTIES IS THE PATIENT INCAPABLE OF PERFORMING?

DO YOU EXPECT A FUNDAMENTAL OR MARKED CHANGE IN THE FUTURE?

◯ **YES, WHEN WILL PATIENT RECOVER SUFFICIENTLY TO PERFORM DUTIES?** ◯ **1 MO.** ◯ **1-3 MO.** ◯ **3-6 MO.** ◯ **OTHER (MM/DD/YYYY):**
◯ **NO, PLEASE EXPLAIN:**

ATTENDING PHYSICIANS STATEMENT CONTINUES ON NEXT PAGE

B. ATTENDING PHYSICIANS STATEMENT: CONTINUED...

11. REHABILITATION:

IS PATIENT A SUITABLE CANDIDATE FOR FURTHER REHABILITATION SERVICES? (I.E. CARDIOPULMONARY PROGRAM, SPEECH THERAPY, ETC.):

◯ **YES** ◯ **NO**

WOULD JOB MODIFICATION ENABLE PATIENT TO WORK WITH IMPAIRMENT?

◯ **YES*** ◯ **NO** ***IF YES, PLEASE EXPLAIN UNDER REMARKS SECTION (BELOW)**

PATIENT'S HEIGHT:	PATIENT'S WEIGHT:

WHEN COULD TRIAL EMPLOYMENT BEGIN (MM/DD/YYYY):

PATIENTS JOB: ◯ **FULL-TIME** ◯ **PART-TIME** **DATE (MM/DD/YYYY):**

ANY OTHER JOB: ◯ **FULL-TIME** ◯ **PART-TIME** **DATE (MM/DD/YYYY):**

WOULD VOCATIONAL COUNSELING AND/OR RETRAINING BE RECOMMENDED?

◯ **YES** ◯ **NO**

11. REMARKS:

PLEASE PRINT:

NAME (ATTENDING PHYSICIAN):

DEGREE/SPECIALITYt:	TELEPHONE NO.

PHYSICIAN'S MAILING ADDRESS: CITY: STATE: ZIP CODE:

TAXPAYER IDENTIFYING NUMBER:

X _____ _____

PHYSICIAN'S SIGNATURE (NOT VALID UNLESS SIGNED IN INK): **DATE SIGNED** (MM/DD/YYYY):

➡ Return to the Administration Department at BAC, PO Box 107, Reynoldsburg, OH 43068-0107.