



Group Claims Ongoing Attending Provider's Statement

Group Claims. PO Box 14333. Lexington, KY 40512
LTD Phone 800 538 4583
Fax 610 807 8221

Claimant Full Name:	DOB:
LTD Case Number:	LTD Claim Number:

Please attach pertinent medical records, not limited to progress notes, diagnostic testing, discharge summaries, operative reports, consultations, or mental status exams.

Patient Height: _____ Patient Weight: _____

Full name and qualification of person completing this form: _____

DIAGNOSIS

Primary Diagnosis: _____ ICD-10: _____

Secondary Diagnosis: _____ ICD-10: _____

Objective Symptoms: _____

TREATMENT

Our goal is to understand the extent to which your Patient is impaired by the condition(s) you have certified above.

Date of most recent visit: _____ Date of next office visit: _____

Frequency of visits: ☐ Weekly ☐ Monthly ☐ Yearly ☐ Other: _____

Current recommendation and treatment plan: (include medications/ frequency, therapies, rehabilitation, etc...)

Has your patient been compliant with the Treatment Plan? ☐ No ☐ Yes

If no, please elaborate: _____

Claimant Name: _____ D.O.B.: _____

Based on your treatment plan, when do you expect the claimant will return to their previous functional levels?
Please elaborate:

Have you discussed the treatment plan and expectations for recovery with your patient? ☐ No ☐ Yes

Is your patient in agreement with the goals and expected outcome of the Treatment Plan? ☐ No ☐ Yes

Has surgery been performed? ☐ No ☐ Yes

If yes, procedure(s) and date(s): _____

Has the claimant been hospitalized? ☐ No ☐ Yes

If yes, admission date(s): _____

PROGRESS

Patient is currently (please check all applicable):

- | | | | |
|--|--|---|--|
| ☐ Recovered | ☐ Improved | ☐ Unchanged | ☐ Retrogressed |
| ☐ Ambulatory | ☐ Bed confined | ☐ House confined | ☐ Hospital confined |
| ☐ Wheelchair confined | ☐ Nursing Home/Assisted Living confined | | |

Based on your most recent examination of this patient, in your opinion, does your patient have some capacity for work? ☐ Yes ☐ No

If yes, as of what date: _____ ☐ Full-time ☐ Part-time

If no, when do you anticipate the ability to work? _____ ☐ Full-time ☐ Part-time ☐ Never

Detail restrictions provided:

PATIENT ABILITIES

The following questions address your patient's current abilities and how it affects them in an 8-hour workday.
Based on a typical 8-hour workday your patient can:

Patient can SIT:	
At one time:	Total hours during the day:
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

If positional change is required, what type of positional change is needed and how long (in minutes) is needed?

Patient can STAND:

At one time:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

Total hours during the day:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

If positional change is required, what type of positional change is needed and how long (in minutes) is needed?

Patient can WALK:

At one time:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

Total hours during the day:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

If positional change is required, what type of positional change is needed and how long (in minutes) is needed?

Patient can ALTERNATIVELY sit/stand:

At one time:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

Total hours during the day:

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8

If positional change is required, what type of positional change is needed and how long (in minutes) is needed?

Handling Restrictions and Hand Use:

Dominant hand:	☐ Right	☐ Left
Perform simple grasp:	☐ Right	☐ Left
Perform firm grasp:	☐ Right	☐ Left
Perform fine manipulation:	☐ Right	☐ Left

Foot Controls: Ability to use feet for movements
(example: pushing/ pulling leg controls)

Right:	☐ Yes	☐ No
Left:	☐ Yes	☐ No
Both:	☐ Yes	☐ No

Patient can Lift/Carry:

Up to 5 lbs.

Never:
0%

☐

Occasionally:
1-33%

☐

Frequently:
34-66%

☐

Continuously:
67-100%

☐

Claimant Name: _____ D.O.B.: _____

Patient can Lift/Carry:	Never: 0%	Occasionally: 1-33%	Frequently: 34-66%	Continuously: 67-100%
6-10 lbs.	☐	☐	☐	☐
11-20 lbs.	☐	☐	☐	☐
21- 25 lbs.	☐	☐	☐	☐
26 – 50 lbs.	☐	☐	☐	☐
51 – 75 lbs.	☐	☐	☐	☐
76 – 100 lbs.	☐	☐	☐	☐

Patient can Push/Pull:	Never: 0%	Occasionally: 1-33%	Frequently: 34-66%	Continuously: 67-100%
Up to 5 lbs.	☐	☐	☐	☐
6-10 lbs.	☐	☐	☐	☐
11-20 lbs.	☐	☐	☐	☐
21- 25 lbs.	☐	☐	☐	☐
26 – 50 lbs.	☐	☐	☐	☐
51 – 75 lbs.	☐	☐	☐	☐
76 – 100 lbs.	☐	☐	☐	☐

Patient can:	Never: 0%	Occasionally: 1-33%	Frequently: 34-66%	Continuously: 67-100%
Bend/Twist/Stoop	☐	☐	☐	☐
Squat/Crouch	☐	☐	☐	☐
Crawl/Kneel	☐	☐	☐	☐

Patient can:	Never: 0%	Occasionally: 1-33%	Frequently: 34-66%	Continuously: 67-100%
Climb	☐	☐	☐	☐
Balance	☐	☐	☐	☐
Reach at or below shoulders	☐	☐	☐	☐
Reach above shoulders	☐	☐	☐	☐
Operate computer/office devices	☐	☐	☐	☐
Use power equipment/heavy machinery	☐	☐	☐	☐
Work at heights	☐	☐	☐	☐
Drive	☐	☐	☐	☐

Claimant Name: _____ D.O.B.: _____

Patient can be exposed to:	Yes	No	Explain:
Climate changes: hot/cold, sun/rain/snow, etc	☐	☐	
Noise	☐	☐	
Dust, Fumes, Gases, Chemicals, etc.	☐	☐	
Vibration	☐	☐	

The abilities listed on this form are based on: ☐ Self-reported by patient ☐ Objective Findings

The restrictions listed on this form are: ☐ Permanent ☐ Temporary:

Length of restriction(s): _____

Do you believe this person is competent to endorse checks and direct proceeds? ☐ Yes ☐ No

Overall Provider Remarks

Please supply any additional comments you deem relevant:

Provider Information and Certification

If any portion of this form is not completed, we will be required to request additional information. This may result in a delay in the determination of your patient's Long Term Disability benefit.

Provider's Name (print):	Degree:	Tax ID Number:
Address:		
Phone Number:	Fax Number:	

Acknowledgement

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statements of claim containing any materially, false information, or conceals for purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and may also be subject to civil penalties, or denial of insurance benefits.

Provider Signature

Date

Fraud Warning Statements

The laws of several states require the following statements to appear on the claim form:

Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

Arkansas, West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: 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.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant regarding a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Connecticut, Iowa, Nebraska, and Oregon: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of a fraudulent insurance act, which may be a crime, and may also be subject to civil penalties.

Delaware, Indiana, and Oklahoma: WARNING: Any person who knowingly, and with the intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.

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.

Idaho: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Kansas: Any person who knowingly, and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, may be guilty of insurance fraud as determined by a court of law.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

Louisiana and Texas: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit is guilty of a crime and may be subject to fines and confinements in state prison.

New Mexico: Any person who knowingly presents a false or fraudulent claim for payment or a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties or denial of insurance benefits.

Maine, Tennessee, and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines, or a denial of insurance benefit.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Minnesota: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in N.H. Rev. Stat. Ann. § 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: 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.

Ohio: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application, or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Pennsylvania: 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 subjects such person to criminal and civil penalties.

Rhode Island: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Vermont: It is a crime for any person knowingly to provide materially false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company, for any person knowingly to provide material false, incomplete, or misleading information concerning the sale of insurance or the status of an insurer, or for any person to misappropriate the funds of an insured or an applicant for insurance. Penalties include imprisonment, fines, and denial of insurance benefits.

Virginia: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.