

<b>Attending Physician's Statement</b>				<b>Mail or Fax to:</b>	
Your patient is applying for Disability Benefits. <b>To be completed by the Treating Physician</b> <b>(Incomplete forms will be returned)</b>		<b>Employer Name</b>		<b>TRISTAR Benefit Administrators</b> PO Box 32363, Long Beach, CA 90832 Tele: 877/ 874-3518 Fax: 562/495-6687	
Patient's Last Name		First Name		Middle Initial	
				Social Security Number -- --	
Date of Birth	Height	Weight	Blood Pressure		Gender <input type="checkbox"/> Female <input type="checkbox"/> Male
The Genetic Information Non-Discrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. Genetic information as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.					
Primary Diagnosis, including ICD9 or DSM code			Secondary Diagnosis, including ICD9 or DSM Code		
If patient is pregnant, give LMP date			If patient is pregnant give EDC		
First Date of Treatment			Last Date of Treatment		
Is the patient still under your care for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No			How often do you see the patient?		
Symptoms					
Is the condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" please explain:				Have you submitted a workers' compensation form? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Has the patient undergone surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" please give date, procedure and result:			Will surgery be performed in the future? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" please give date and procedure:		
Medications taken at present					
Has the patient been referred for medical rehab or therapy to another physician? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" please give details:					
Was the patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" please give dates: From _____ through _____			Name and address of hospital		
Limitations on patient's activities to include occupations restrictions and limitations:					
Prognosis for recovery					
Patient <b>continuously</b> disabled from doing regular work From _____ Through _____			<b>OR</b> Will the patient require intermittent or reduced schedule? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):					
Frequency: _____ times per _____ week(s) _____ month(s)			Is the patient competent to handle his/her financial affairs? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Duration: _____ hours or _____ day(s) per episode					
<b>If still disabled, when should patient be able to Return to Work?</b> <b>(Specific date required)</b>					
I hereby certify that the above statements truly describe the patient's disability (if any) and the estimated duration thereof. If I am a Nurse Practitioner I certify that I performed a physical examination of the above patient and that I collaborated with a physician prior to certifying the period of disability stated above.					
Print or Type Physician's/Nurse Practitioner's Name as shown on License			State License #		
Address			City, State, Zip		
Telephone			Fax		
Signature: (NO STAMP)				Date	