Must Be Returned by: «FormDueDate»
Return to: P.O. Box 6248
Broomfield, CO 80021
FAX: 720-279-6783
Toll-Free FAX: 1-866-828-4967

Date Sent:

INSTRUCTIONS: The following sections must be completed and signed by the attending physician. The purpose of this report is to assist us in making a disability determination. If this claim is related to a normal pregnancy, complete the normal pregnancy section. Otherwise, please complete all the applicable sections of this form and provide copies of supporting reports such as office notes, medical records, consultations and/or testing. In all situations, you must complete the signature block at the bottom of this form.

ATTENDING PHYSICIAN'S STATEMENT (Please Print)

Patient: «EmployeeFullName» Absence ID: «AbsenceID»	Date of Birth: «EmployeeDOB»	**Employer Name:** Chevron

Normal Pregnancy

Expected Delivery Date: _____ Actual Delivery Date _____ Date First Unable to Work:_____

Date Hospitalized: _____ Delivery Type: ☐ Vaginal ☐ C-Section

All Other Conditions

a) Height: _____ Weight: _____ b) Date of first visit regarding current condition(s): _____

c) Date patient ceased work because of condition? _____

d) Did you advise patient to cease work? ☐ Yes ☐ No If yes, when? _____

e) Has the patient been treated for the same/similar condition in the past? ☐ Yes ☐ No If yes, when? _____
Please describe:

f) Is the patient's condition due to injury or sickness involving the patient's employment? ☐ Yes ☐ No ☐ Unknown

Diagnosis and Treatment

Primary Diagnosis

b) What is the primary diagnosis preventing your patient from working?

c) Please include Primary ICD-10 and/or DSM IV Multi-Axial Diagnoses and codes:

d) Date of last examination: _____ Date of Next Scheduled visit:_____ Final Date of Treatment _____

e) Describe reported symptoms:

f) Describe Physical Findings (MRIs, X-rays, EMG/NCV studies, lab tests, clinical findings, etc.)

Other Conditions (Please attach additional information as necessary-i.e. Office notes, lab, x-rays)

a) Are there other conditions that prevent your patient from working? ☐ Yes ☐ No If yes, please provide the following:

b) Secondary ICD-10: _____ Diagnosis: _____

c) Secondary ICD-10: _____ Diagnosis: _____

Other: _____

Please see addendum for Genetic Information Nondiscrimination Act.

DO NOT PROVIDE GENETIC INFORMATION.

Patient: «EmployeeFullName»	Date of Birth: «EmployeeDOB»	**Absence ID:** «AbsenceID»

Treatment

a) Describe the patient's current treatment program:

b) Please list all Medications (attach separate sheet if additional space is needed):

Medication	Dosage	Frequency	Date Started

c) Has the patient been hospitalized? ☐ Yes ☐ No If yes, Dates Hospitalized:_____ through_____

d) Was surgery performed? ☐ Yes ☐ No If yes, Date Surgery Performed: _____

Type of Surgery: _____ CPT 4 code(s): _____

e) Is the patient still under your care? ☐ Yes ☐ No

Work Status

Functional Status

Has the patient been totally unable to work? ☐ Yes ☐ No If yes, From_____ through_____

☐ a) The employee **is not allowed to return to work at this time due to:**

_____

_____

☐ b) The employee **may return to work with restriction(s) as of** _____which are expected to last until _____. Please describe in detail what activities the employee should not do:

_____

_____

☐ c) The employee **may return to work Full Time / Full Duties** as of _____.

- If Chevron determines that a Functional Capacity Evaluation (FCE) is needed (done by a provider contracted by Chevron), may the FCE be performed when you release the employee to full work duties? Yes _____ No _____

Date released for FCE _____

Fraud Notice: Any person who knowingly files a statement of claim containing false or misleading information is subject to civil and criminal penalties. This includes Attending Physician portions of this claim form.

Are you, the physician related to this patient? ☐ Yes ☐ No If yes, what is the relationship? _____

Attending Physician: Tax ID Number:_____

Name:: _____ Degree: _____ Medical Specialty: _____

Address:_____ Phone # (_____)_____-_____

City/State/ZIP:_____ Fax # (_____)_____-_____

Signature of Physician: _____ Date: _____

Please see addendum for Genetic Information Nondiscrimination Act.

DO NOT PROVIDE GENETIC INFORMATION.

Addendum – GINA Notification

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of employees or their family members. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information unless, with respect to leave to care for a family member with a serious health condition, failure to provide the information will result in an incomplete or insufficient certification. '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 or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.