Sedgwick CMS

PHYSICIAN'S EXTENSION FOR DISABILITY BENEFITS

IMPORTANT: READ INSTRUCTIONS BELOW REGARDING THE ATTACHED FORM AND RETURN TO SEDGWICK CMS IMMEDIATELY.

INSTRUCTIONS FOR PHYSICIAN:

Your patient is requesting that you complete the attached **Physician's Extension** form to extend his/her disability. Unless each question is answered, we cannot process benefit payments and your patient may not get paid.

Please complete the attached statement **immediately** and **fax it to (818) 591-7664.**

If you would prefer to phone in the information, or if you have questions regarding this form, please **call (818) 591-2772** to speak to a Sedgwick CMS Customer Service Representative between the hours of 5:00 a.m. to 5:00 p.m., Pacific Time.

INSTRUCTIONS FOR EMPLOYEE:

It is very important that you have your physician complete the attached **Physician's Extension** form in a timely manner. Sedgwick CMS cannot process your request for disability benefits without proper documentation from your physician.

Have your physician's office follow the instructions above, or request they provide you a copy of the completed form instead so you can **fax the form to (818) 591-7664**. You may also mail the form to Sedgwick CMS / PO Box 9830 / Calabasas, CA 91372-0830, if necessary.

If you have questions regarding this form, please **call (818) 591-2772** to speak to a Sedgwick CMS Customer Service Representative between the hours of 5:00 a.m. to 5:00 p.m., Pacific Time.

Sedgwick CMS

Physician's Extension for Disability Benefits

Your patient's income is directly related to the timely receipt of this information. **Complete and Fax to (818) 591-7664**

Patient's Name:	Phone:	Claim Nbr or Last four digits of SSN:
Patient's Date of Birth:	Medical Records Nbr (If applicable):	
Employer Name:		

A. Patient Information (MANDATORY):

Primary CPT/ICD Code	Diagnosis / Procedure Description			
Secondary CPT/ICD Code	Diagnosis / Procedure Description			
Is this condition work related? Accident related?	☐ No ☐ Yes ☐ No ☐ Yes Date of Accident:			
Physical Exam Findings/Symptoms Diagnostic Tests and Results				
Current Medications				
Assistive devices in use by patient (Check all that apply)	☐ **Wheelchair** ☐ **Crutches** ☐ **Cane** ☐ **Walker** ☐ **Brace** ☐ **Other:**			
Disability Start Date	Disability End Date	1st Treatment Date	Last Appointment Date	Next Scheduled Appt. Date

B. Complete this Section if Patient is Hospitalized or Surgery Performed or Planned:

Date admitted	Date discharged	Surgery date	
Hospital/Surgical facility name	City	State	Telephone number

C. Complete this Section for Physical and/or Mental Limitations :

What limits the patient's ability to do their job?		
Is patient on light duty?	☐ No ☐ Yes → Light duty start date: _____	Light duty end date: _____
List physical/mental limitations:		List number of hours per day_____
Restricted hours start date	List restricted hours	Restricted hours end date

D. Complete this Section if the Patient has been Referred to Another Physician or Provider:

Has patient been referred to another physician or other provider for this illness?	☐ No ☐ Yes		
	Referred Physician's Name:	Specialty	Office Number

E. Physician Information (All Information in this Section Must be Completed and Form Signed Below):

Physician's Name (print)	Specialty	License #	Licensing State
Select Appropriate Professional Designation	☐ MD ☐ DO ☐ DPM ☐ Ph.D. ☐ CNM ☐ Other (Please Specify _____ (CNM may only certify standard pre and post partum period. PAC's, NP's and Therapists, other than PHD's, cannot certify or extend a disability.)		
Address	City	State	Zip
Office Number	Fax Number	HMO Name/# (If applicable)	

***Important:** 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 an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking you and your health care provider not to 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 or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

I hereby certify the above statement in my opinion truly describes the patient's condition and the estimated duration thereof.

X Physician's Signature:	**Date:**

FAX COMPLETED FORM TO **818-591-7664** OR MAIL TO SEDGWICK CMS / PO BOX 9830 CALABASAS, CA 91372-0830
For questions, call **818-591-2772** between the hours of 5:00 a.m. to 5:00 p.m., Pacific Time.