



## 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?	<input type="checkbox"/> No <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> Yes	Date of Accident:	
Physical Exam Findings/Symptoms Diagnostic Tests and Results				
Current Medications				
Assistive devices in use by patient (Check all that apply)	<input type="checkbox"/> Wheelchair <input type="checkbox"/> Crutches <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> Brace <input type="checkbox"/> Other:			
Disability Start Date	Disability End Date	1 <sup>st</sup> 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?	<input type="checkbox"/> No <input type="checkbox"/> 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?	<input type="checkbox"/> No <input type="checkbox"/> 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	<input type="checkbox"/> MD <input type="checkbox"/> DO <input type="checkbox"/> DPM <input type="checkbox"/> Ph.D. <input type="checkbox"/> CNM <input type="checkbox"/> Other (Please Specify _____)			
Address		City	State	Zip
Office Number	Fax Number	HMO Name/# (If applicable)		

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

<b>X</b> Physician's Signature:	Date:
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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.