PHYSICIAN'S CERTIFICATE 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 Certification** form to certify 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 Certification** 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.

Physician's Certification 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 Description
Secondary CPT/ICD Code	Diagnosis 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 Pregnancy Related:

Actual Delivery Date (or EDC)	☐ Vaginal delivery ☐ C-Section	*Post Delivery Recovery Period: ________ Weeks*

C. 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

D. 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

E. 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

F. 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)	

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.