SHORT TERM DISABILITY CLAIM FORM

The Benefits Center
P.O. Box 100158
Columbia, SC 29202-3158
www.unum.com
Toll-free: 1-800-858-6843 Fax: 1-800-447-2498
Call toll-free Monday through Friday, 8 a.m. to 8 p.m. (Eastern Time)

ATTENDING PHYSICIAN STATEMENT (PLEASE PRINT)

TO BE COMPLETED BY PHYSICIAN OR TREATING PROVIDER

Name of Patient (Last Name, Suffix, First Name, MI)

Social Security Number

Patient Address

City

State

Zip

Date of Birth (mm/dd/yy)

Patient Telephone Number

Employer Name

A. Complete this section for pregnancy, then go to Section C

Expected Delivery Date (mm/dd/yy):	Actual Delivery Date (mm/dd/yy):	Delivery Type: ☐ Vaginal ☐ C-Section	Date of first visit for this pregnancy (mm/dd/yy):	Date Hospitalized (mm/dd/yy):

Diagnosis:	ICD Code:	Did you advise your patient to stop working? ☐ Yes ☐ No If yes, on what date (mm/dd/yy)?

Were there any complications causing your patient to stop working prior to her expected delivery date? ☐ Yes ☐ No
If yes, please explain:

B. Complete this section for all conditions except pregnancy, then go to Section C

Date of first visit for this current condition(s) (mm/dd/yy):	Date of last office visit (mm/dd/yy):	Date of next office visit (mm/dd/yy):	Did you advise your patient to stop working? ☐ Yes If yes, on what date (mm/dd/yy)? ☐ No

Has the patient been treated for the same/similar condition in the past? ☐ Yes ☐ No ☐ Unknown

If yes, please provide treatment dates (mm/dd/yy): From Through

Is the patient's condition work related? ☐ Yes ☐ No ☐ Unknown	Patient's Height:	Patient's Weight

Primary Diagnosis:	Primary ICD Code:

Secondary Diagnosis:	Secondary ICD Code:

Has the patient been hospitalized? ☐ Yes ☐ No	If yes, date hospitalized (mm/dd/yy): through (mm/dd/yy):

Was surgery performed? ☐ Yes ☐ No If yes, what procedure was performed?	CPT Code:	Date Surgery Performed (mm/dd/yy):

What is your treatment plan? Please include all medications.

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ATTENDING PHYSICIAN STATEMENT (Continued)

Patient Name (Last Name, First Name, MI, Suffix) | Date of Birth (mm/dd/yy)

Other Providers: Are you aware of or have you referred your patient to other treating providers? If yes, please provide complete name, contact information and specialty of any other treating physicians.

Name	Specialty	Address	Phone #

Have you advised the patient to return to work? ☐ Yes ☐ No

Expected return to work date (mm/dd/yy): ☐ Full Time ☐ Part Time

Part-time hours per day

C. Functional Capacity

If your patient ***does not*** have physical and/or behavioral health RESTRICTIONS (activities patient should not do) and/or LIMITATIONS (activities patient cannot do), please initial here _____ and go to ***SECTION D.***

Please note: When considering a standard 8 hour workday with breaks (approximately every two hours) please quantify terms that may not be uniformly understood such as “prolonged”, “repetitive”, “light-duty”, “heavy lifting”, or “stressful situations”. In addition, never means not at all, occasional means more than never but less than 33% of the time; frequent means 34-66% of the time, and constant means 67-100% of the time.

Restrictions and/or Limitations

If your patient has CURRENT RESTRICTIONS (activities patient should not do) and/or LIMITATIONS (activities patient cannot do) list below. Please be specific and understand that a reply of “no work” or “totally disabled” will not enable us to evaluate your patient’s claim for benefits and may result in us having to contact you for clarification.

Please provide the duration of these restrictions and limitations. From (mm/dd/yy): _____ To (mm/dd/yy): _____

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

D. Signature of Attending Physician

The above statements are true and complete to the best of my knowledge and belief.

Physician Name (Last Name, First Name, MI, Suffix) Please Print | Degree/Specialty

Address

City | State | Zip

Telephone Number | Fax Number | Physician Tax ID Number: | Are you related to this patient? ☐ Yes ☐ No
If yes, what is the relationship?

Signature of Physician | **Date**

X