Prominence Health Plan

Primary Treating Physician's Dependent Disability Verification

Member Name ____

ID# _________________________________ DOB _________________________________

Relevant Medical History:

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Date of Onset of Disability: ___________________________

<u>Objective Finding</u>

Physician Examination: (Describe all relevant findings; include any specific measurements including atrophy, range of motion, strength)

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Diagnostic Test Results: (X-ray, imaging, laboratory, etc.)

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Diagnoses: (List each diagnosis; ICD-10 code must be included) ICD-10

1. _____________________________________ _______________________

2. _____________________________________ _______________________

3. _____________________________________ _______________________

4. _____________________________________ _______________________

	Yes	No	Cannot Determine
Did work cause or contribute to the injury or illness?	☐	☐	☐
Can this patient now return to his/her usual occupation?	☐	☐	☐
If not, can the patient perform another line of work?	☐	☐	☐

Physician Name: ____ Date: ___________________

REV MAY 2017