Please fax the completed form to:
Fax Number: 866-411-5613
The Hartford
P.O. Box 14301
Lexington, KY 40512-4301
Email: APSupload@thehartford.com

Attending Physician's Statement – Initial

The patient is responsible for completion of this form without expense to the company

Patient Last Name: | Patient First (or Preferred) Name: | Date of Birth: | Claim Id Number:

Condition

Patient's condition is a result of:
☐ Illness ☐ Injury
☐ Pregnancy

If illness or injury, is condition related to:
☐ Work Activity
☐ Motor Vehicle Accident
☐ Intentional/Self-Inflicted

If pregnancy, what is date of delivery?
__/__/____ (MM DD YYYY) ☐ Actual ☐ Estimated

Condition onset: __/__/____ (MM DD YYYY)

First day recommended out of work: __/__/____ (MM DD YYYY)

Projected return to work date: __/__/____ (MM DD YYYY)

Office visit to complete this form: __/__/____ (MM DD YYYY) ☐ In Person ☐ Telemedicine

Disabling Diagnosis(es) and Impact to Function

ICD 10 Codes
Please provide most specific codes:
|__||__||__|.|__||__||__||__| \ |__||__||__|.|__||__||__||__|

Description of corresponding symptoms
____
____

Co-Morbid Conditions with Impact to Diagnosis

☐ None ☐ Opioid Usage ☐ Psoriasis ☐ Mental Health
☐ Diabetes ☐ Heart Disease ☐ Asthma/Bronchitis ☐ Cognitive Impairment
☐ Hypertension ☐ Obesity ☐ Auto-Immune Disease
☐ COPD ☐ Arthritis ☐ Other ____________

In your opinion is the patient competent to endorse checks and direct the use of proceeds? ☐ Yes ☐ No

Treatment Plan

☐ Conservative treatment ☐ Bed Rest ☐ Palliative care ☐ Hospice Care

☐ Hospitalization Admittance date: __/__/____ (MM DD YYYY) Discharge date: __/__/____ (MM DD YYYY)

☐ Next/Another appointment Date: __/__/____ (MM DD YYYY) ☐ In Person ☐ Telemedicine

☐ Physical/Occupational therapy |__| times per week ☐ until __/__/____ (MM DD YYYY) ☐ Actual ☐ Estimated

☐ Surgery Date: __/__/____ (MM DD YYYY) CPT Code(s): |__||__||__||__||__| \ |__||__||__||__||__|

☐ Referral to a specialist Type: ________________________ Contact Info:________________________________

Current Medications (related to condition or impacting function)

☐ None ☐ Over counter medications: ____

☐ Prescription medications Name(s): ____
☐ Impacting function? ☐ Yes ☐ No If yes, why? ____

☐ Chemotherapy ☐ Radiation Start Date: __/__/____ (MM DD YYYY) End Date: __/__/____ (MM DD YYYY)

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Level of Functionality (Based upon your medical findings and opinion, address the full range of your patient's abilities. We will conclude that there are no restrictions on function unless specified below.)

Expected duration of any restriction(s) or limitation(s) listed below THROUGH _ _ /_ _ /_ _ _ _ (MM DD YYYY)

In a workday the patient is able to: (select either Continuous or Intermittent)

	Continuously with standard breaks		Intermittently with standard breaks	If intermittent, enter time for each section below	
				Hours at one time	Total hours in a workday
Sit	☐	or	☐	|___|	|___|
Stand	☐	or	☐	|___|	|___|
Walk	☐	or	☐	|___|	|___|

Key: C = Continuously (5.5 – 8 hours) F = Frequently (2.5 – 5.5 hours) O = Occasionally (up to 2.5 hours) N = Never

Activity Ability	C	F	O	N
☐ Drive	☐	☐	☐	☐
☐ Weight bearing	☐	☐	☐	☐
☐ Climb	☐	☐	☐	☐
☐ Bend	☐	☐	☐	☐
☐ Max lift	____LBS	____LBS	____LBS	____LBS
☐ Max Carry	____LBS	____LBS	____LBS	____LBS

Activity Ability	Right/Left	C	F	O	N
☐ Squat / Kneel		☐	☐	☐	☐
Hand Dominance	☐ R ☐ L				
☐ Fine Manipulation	☐ R ☐ L	☐	☐	☐	☐
☐ Gross Manipulation	☐ R ☐ L	☐	☐	☐	☐
☐ Reach above shoulder	☐ R ☐ L	☐	☐	☐	☐
☐ Reach below shoulder	☐ R ☐ L	☐	☐	☐	☐

Completed or Planned Diagnostic Tests, Labs and Imaging (related to the disabling diagnosis)

Completed: ☐ X-ray _ _/_ _/_ _ _ _ (MM DD YYYY) ☐ MRI _ _/_ _/_ _ _ _ (MM DD YYYY) ☐ CT _ _/_ _/_ _ _ _ (MM DD YYYY) ☐ EKG _ _/_ _/_ _ _ _ (MM DD YYYY)

☐ ECHO _ _/_ _/_ _ _ _ (MM DD YYYY) ☐ EMG _ _/_ _/_ _ _ _ (MM DD YYYY) ☐ Lab Work _ _/_ _/_ _ _ _ (MM DD YYYY)

Findings of completed tests: ☐ No significant findings ☐ Confirmed diagnosis

Planned: ☐ X-ray ☐ MRI ☐ CT ☐ EKG ☐ ECHO ☐ EMG ☐ Lab Work Scheduled date _ _/_ _/_ _ _ _ (MM DD YYYY)

Provider Details

Provider Name: ______________________________

Specialty: ______________________________

EIN Number: ______________________________

License Number: ______________________________

Email: ________________________

Phone: (_ _ _) _ _ _ - _ _ _ _

Fax: (_ _ _) _ _ _ - _ _ _ _

Provider Signature: ____

Date: _ _/_ _/_ _ _ _ (MM DD YYYY)