



The Prudential Insurance Company of America
Disability Management Services
P.O. Box 13480, Philadelphia, PA 19176
Tel: 800-842-1718 Fax: 877-889-4885
www.prudential.com/forphysicians

Attending Physician Statement

1 Employee Information

Employer's Name, Control Number (required), Employee First Name, MI, Last Name, Claim Number, Social Security Number, Date of Birth (MM DD YYYY), Gender (Male/Female)

I hereby authorize the release of information requested on this form by the below named physician for the purpose of claim processing.

Employee Signature, Date (MM DD YYYY)

The Employee is responsible for the completion of this form without expense to Prudential.

2 To Be Completed by Attending Physician

Clinical Diagnosis, ICD Code is Required, Pregnancy EDC (MM DD YYYY), Actual Delivery Date (MM DD YYYY), Date when significant loss of function occurred: (MM DD YYYY)

Do you feel the claimant is competent to endorse checks and direct the use of proceeds? Yes No

Return to Work Target Date (MM DD YYYY), Full-Time, Part-Time, With Limitations (functions lost)

Please describe Return to Work Plan and provide any corresponding Limitations:

Please describe any Medical Obstacles to Return to Work:

Nature of Medical Impairment (i.e., loss of function):

Are there any Non-Medical Factors which have a significant impact on Functional Abilities (i.e., interpersonal, financial, family)?

Check all that apply to this disability:

Work Related, Accident, Sickness, Maternity, Motor Vehicle Accident, If MVA, in what State did it occur? Yes/No checkboxes

Other Treating Physicians or Consultants:

First Name, Last Name, Specialty, Telephone Number





Employee First Name MI Last Name
 Claim Number Date of Birth (MM DD YYYY) Employee's Social Security Number

2 Attending Physician Information (Cont'd)

Other Treating Physicians or Consultants

First Name Last Name

Specialty Telephone Number

Date of Surgical Procedure (MM DD YYYY)

Relevant tests and surgical procedure (s) performed (please be specific):

Current Medications, Treatment, and Prognosis:

First Visit (MM DD YYYY) Last Visit (MM DD YYYY) Next Visit (MM DD YYYY) Was Claimant hospital confined? Yes No

If yes, please provide name and address of hospital:

From (MM DD YYYY)

To (MM DD YYYY)

3 Physician Information

First Name MI Last Name

Primary Telephone Number Fax Number

Office Address Suite

City State ZIP Code

Specialty

4 Fraud Notice

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

I have read and understand the terms and requirements of the fraud warning and I certify the above statements are true.

Physician Signature

Date (MM DD YYYY)

