MetLife

Attending Physician Statement

Use this form to provide us with the information we need from you and your physician to process your claim for disability benefits.

Metropolitan Life Insurance Company

Things to Know Before You Begin

- You should complete and sign Section 1 of this form before giving it to your physician. If the form is sent directly to your physician, you may have your physician complete Section 1 for you. Section 2 **MUST** be completed by your physician.
- Submitting an incomplete form may delay processing your claim.
- Some physicians may charge for completion of this form. Any such charge is your responsibility.
- **New York**: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Please write the claim number on any additional documents you send.

SECTION 1: Claim Information (To be completed by the person submitting the claim, or by the physician if received directly.)

Claimant First Name	Middle Name	Last Name

Date of Birth *(mm/dd/yyyy)*	Customer Name	Occupation

Physician First Name	Last Name

Physician Phone Number	Claim Number

Authorization For Physician to Share My Medical Information

I authorize my physician to release to MetLife Disability any information collected in the course of examining or treating me as a patient.

Sign Here	Claimant Signature	Date *(mm/dd/yyyy)*

REQUIRED information in case pages get separated:

Claimant First Name	Middle Name	Last Name	Claim Number

SECTION 2: Information About Your Patient's Health (To be completed by the physician providing treatment for the disability condition.)

- Please provide all applicable information requested about your patient. The information you share will be used in making a decision about your patient's claim for disability benefits.
- **After you complete this form, please submit it along with office notes and results from any diagnostic testing related to your patient's condition *(e.g., x-ray, lab tests, EKG or MRI)***. See Section 4 below for instructions on how to submit this completed form and any supporting documents to MetLife Disability.

History Of Your Patient's Condition

First date of treatment for this condition *(mm/dd/yyyy)*	Most recent date of treatment *(mm/dd/yyyy)*

What is the cause of your patient's symptoms? *(Check one)*

☐ Injury

☐ Illness

☐ Pregnancy (*Type of birth* - ***Check one below***)

☐ Cesarean ☐ Natural Birth ☐ Not yet delivered: Expected delivery date *(mm/dd/yyyy)* _____

List any other physicians or specialists you referred your patient to:

First name	Last name	Specialty	Phone number

Is your patient's condition work-related? ☐ Yes ☐ No

Did you advise your patient to stop working? ☐ Yes On date *(mm/dd/yyyy)* _____ ☐ No

Has your patient been hospitalized for this condition? ☐ Yes On date *(mm/dd/yyyy)* _____ ☐ No

Facility Name

Address	City	State	ZIP

About The Diagnosis And Treatment Of Your Patient

Primary Diagnosis Code	Description

Secondary Diagnosis Code	Description

REQUIRED information in case pages get separated:

Claimant First Name	Middle Name	Last Name	Claim Number

List the symptoms your patient reported to you.

List your clinical findings and reports. *(Please include copies of results when you return this form to us)*

Describe the treatment plan you recommend for your patient.

If surgery has been performed or is anticipated, provide:

CPT-4 procedure code	Description	Date *(mm/dd/yyyy)*

List any medications prescribed:

Medication name	Dosage

About Your Patient's Restrictions and Limitations

Your patient's dominant hand *(Check One):* ☐ Right ☐ Left

How many hours in a workday can your patient:

	Hours *(0 to 8)*	Continuously	Intermittently	Breaks Frequency	Duration
Sit		☐	☐		
Stand		☐	☐		
Walk		☐	☐		
Climb		☐	☐		
Twist/Bend/Stoop		☐	☐		
Reach above shoulder level		☐	☐		
Reach front and side at desk level		☐	☐		
Perform fine finger movements		☐	☐		
Perform eye/hand movements		☐	☐		

REQUIRED information in case pages get separated:

Claimant First Name	Middle Name	Last Name	Claim Number

How many hours in a workday can your patient lift or carry:

	Hours *(0 to 8)*	Continuously	Intermittently	Breaks Frequency	Duration
Up to 10 lbs.		☐	☐		
11 to 20 lbs.		☐	☐		
21 to 50 lbs.		☐	☐		
51 to 100 lbs.		☐	☐		
Over 100 lbs.		☐	☐		

How many hours in a workday can your patient push or pull:

	Hours *(0 to 8)*	Continuously	Intermittently	Breaks Frequency	Duration
Up to 10 lbs.		☐	☐		
11 to 20 lbs.		☐	☐		
21 to 50 lbs.		☐	☐		
51 to 100 lbs.		☐	☐		
Over 100 lbs.		☐	☐		

Can your patient operate a motor vehicle? ☐ Yes ☐ No

Is your patient at maximum medical improvement? ☐ Yes ☐ No

Please make any additional notes.

About Your Patient's Prognosis

Have you advised your patient when they can return to work?

☐ Yes *(Check all that apply)*

☐ To regular occupation. On date *(mm/dd/yyyy)* _____ ☐ Full-time ☐ Part-time ☐ Modified duty

☐ To any other occupation. On date *(mm/dd/yyyy)* _____ ☐ Full-time ☐ Part-time ☐ Modified duty

☐ No *(Please explain)*

List any restrictions to work or activity. *(Please be as specific as possible.)*

REQUIRED information in case pages get separated:

Claimant First Name	Middle Name	Last Name	Claim Number

If we need more information, who's the best person at your office to contact? *(Please provide name and phone number/extension.)*

SECTION 3: Physician's Signature and Information

First Name	Last Name

Address	City	State	ZIP

Degree or Specialty	Office Phone Number	Office Fax Number	Tax ID

Sign Here	Signature of Physician	Date *(mm/dd/yyyy)*

SECTION 4:

Please send all of the pages of this form and any supporting documents, adding the claim number to the top of each page, to MetLife Disability by:

Mail:
MetLife Disability
PO Box 14590
Lexington KY 40512-4590

Fax:
1-800-230-9531

Fraud Warnings

Before signing this claim form, please read the warning for the state where you reside and for the state where the insurance policy under which you are claiming a benefit was issued.

Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, Minnesota, New Mexico, Ohio, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Alaska: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete or misleading information may be prosecuted under state law.

Arizona: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of life insurance and civil damages. It is also unlawful for any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with respect to a settlement or award from insurance proceeds. Such acts shall be reported to the Colorado Divisions of Insurance with the Department of Regulatory Agencies.

Delaware: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Florida: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Idaho, Indiana and Oklahoma: WARNING: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is guilty of a felony.

Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Maine, Tennessee and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

Maryland: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Hampshire: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Oregon: Any person who knowingly presents a materially false statement of claim may be guilty of a criminal offense and may be subject to penalties under state law.

Pennsylvania and all other states: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Puerto Rico: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Texas: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Vermont: Any person who knowingly presents a false statement of claim for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.