

**ASSOCIATION
ATTENDING PHYSICIAN'S STATEMENT - PROGRESS REPORT**



To be completed by the Insured

Patient Name: _____	Date of Birth: _____	Claim Number (if known): _____
Patient Address: (Street, City, State & Zip Code) _____		

To be completed by the Provider - Use current information from your patient's most recent office visit or examination to complete this form. (The patient is responsible for the completion of this form without expense to the Company.)

Medical Conditions Impacting Activity

Primary condition: _____	ICD-9 Code: <input type="checkbox"/> _____	ICD-10 Code: <input type="checkbox"/> _____
Secondary condition(s): _____	ICD-9 Code: <input type="checkbox"/> _____	ICD-10 Code(s): <input type="checkbox"/> _____
Subjective symptoms: _____		
Objective Physical Findings (Please include office notes for date(s): _____ to _____)		
Pertinent Test Results (list all results or attach test results):		
Test: _____	Date: _____	Results: _____
Test: _____	Date: _____	Results: _____
Condition(s) Specific Medications, Dosage and Frequency: _____		

TREATMENT PLAN

Current Treatment Plan: _____		
What is the Frequency / Duration of Treatment? _____	Dates of Treatment: _____	
First Office Visit for this condition: _____	Last Office Visit: _____	Next Scheduled Office Visit: _____
Has Surgery been performed since last report: <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," on what Date(s): _____		
Procedure(s): _____		CPT Code(s): _____
Was patient hospitalized since last report? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," Hospital name and Phone Number: _____		
Admission date: _____ Discharge date: _____		
Has patient been referred to other physicians? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," Date of Referral(s): _____		
Other Physician Name _____	Phone Number: (____) _____	Specialty: _____
Other Physician Name _____	Phone Number: (____) _____	Specialty: _____

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries, including underwriting companies Hartford Life and Accident Insurance Company and Hartford Fire Insurance Company. Home Office is Hartford, CT. The Hartford is the administrator for certain group benefits business written by Aetna Life Insurance Company and Talcott Resolution Life Insurance Company (formerly known as Hartford Life Insurance Company). The Hartford also provides administrative and claim services for employer leave of absence programs and self-funded disability benefit plans.

Patient Name:

Date of Birth:

Claim Number (if known):

Please complete this section to the best of your ability. Generalized comments such as "unable to work" may delay your patient's disability benefits.

Based on your most recent medical findings and opinion, address the full range of restrictions/limitations, noting that we will conclude there are no restrictions on function unless specified below.

Restrictions/Limitations based on office visit dated: _____ Expected Return to Work date: _____

In an 8 hour period the patient is able to: (select either continuous or intermittent)

	Continuously with standard breaks	or	Intermittently with standard breaks	If intermittent circle time for each section below															
				Hours at one time								Total hours/8 hours							
Sit	<input type="checkbox"/>		<input type="checkbox"/>	1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8
Stand	<input type="checkbox"/>		<input type="checkbox"/>	1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8
Walk	<input type="checkbox"/>		<input type="checkbox"/>	1	2	3	4	5	6	7	8	1	2	3	4	5	6	7	8

Provide medical findings/rationale for your opinion if patient is unable to continuously sit, stand or walk:

Activity Ability (with normal breaks)	Never 0 hours	Occasionally up to 2.5 hours	Frequently 2.5 to 5.5 hours	Constantly 5.5 to 8 hours	Please indicate diagnosis, symptoms, exam findings, and/or imaging that supports the restrictions/limitations
Bend at waist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Kneel/crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Climb	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lift - Indicate weight in pounds		_____ lbs.	_____ lbs.	_____ lbs.	
Other Restrictions (if any)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Hand Dominance: Right Left

Upper Extremity Activity (not load bearing) Specify right (R) or left (L) if not bilateral

Fine manipulation (fingering, keyboard)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gross manipulation (grip/grasp, handle)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reach (extend arms) above shoulder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Reach (extend arms) below shoulder at desk or workbench level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Please attach copies of imaging results/tests

Expected duration of any restriction(s) or limitation(s) listed above: _____

Current Status (Please check one): Recovered Improved Unchanged Retrogressed

Additional Comments (If Necessary): _____

Does the patient have a psychiatric / cognitive impairment? Yes No If "Yes," please describe the extent of the impairment and its etiology: _____

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

Provider's Name: (please print or type) _____ EIN Number: _____ License Number: _____

Telephone Number: () _____ Fax Number: () _____ Degree: _____ Specialty: _____

Street Address (Street, City, State & Zip Code): _____

Office Contact and Telephone Number: _____

Provider's Signature: _____ Date signed: _____