PHYSICIAN FORM FOR HANDICAPPED/DISABLED DEPENDENT

CIGNA

MR Type - for internal use only

DATE	SUBSCRIBER'S NAME (EMPLOYEE)	DEPENDENT'S NAME	
SUBSCRIBER'S ADDRESS STREET:	CITY:	STATE:	ZIP CODE:
NAME OF HEALTH PLAN:		HEALTHPLAN CODE:	ID NUMBER
GROUP NAME			GROUP/DIVISION NUMBER

This form should be completed and signed by the primary treating physician for the dependent named above.

Please mail the completed form to: CIGNA HealthCare
P.O. Box 692012
San Antonio, TX 78269

Treating Physician Information:

Physician Name:

Specialty: License Number:

Address:

Telephone Number: Fax Number:

Diagnosis(es) (ICD-9) _____, _____, _____, _____

A. Student Medical Leave of Absence:

Please complete this section of the form if the patient is requesting a Student Medical Leave of Absence.

Does this patient qualify for a medically necessary Student Medical Leave of Absence?
Yes_____ No_____

If yes, please provide a short explanation below:

Please Continue on Reverse Side

B. Handicapped/Disabled Dependent:

Please complete this section of the form if the patient is requesting certification of handicapped/ disabled status. Please answer the following questions and describe, in as complete a manner as possible, the extent of your patient's behavioral, cognitive and/or physical impairment which prevents gainful employment. This information will assist CIGNA HealthCare in determining this patient's eligibility for continued medical and/or dental coverage as a handicapped/disabled dependent.

1. What is the patient's diagnosis?_____
2. When was the patient's condition initially diagnosed? _____
3. How long have you treated the patient for the specific conditions which impact his/her ability to be gainfully employed? Number of years_____ Frequency of visits_____

Please complete questions 4-11 if your patient is requesting certification of handicapped/ disabled status due to Behavioral Health, Cognitive and/or Neurological Impairment (otherwise, skip to question 12):

4. How many hospital admissions have occurred for this diagnosis/condition in the past 12 months? _____
5. How many hospital admissions have occurred for this diagnosis/condition **prior to** the past 12 months? _____
6. Has the patient had an IQ test? Yes_____ No_____
   If yes, what was the result? _____
7. Describe any cognitive or psychological impairment and the impact created on personal life skills and social interaction:
8. Please provide objective abnormal physical examination findings (e.g. , neurological deficit, contractures, loss of joint motion , etc):
9. Please identify any functional limitations that impair self-sustaining employment:

Please Continue on Next Page

10. Is the condition static/permanent? Yes_____ No_____
    If no, when do you anticipate your patient's condition to improve?
    3 months_____ 6 months_____ 1 year_____ more than 1 year_____

11. Is this patient able to participate in a training or other educational program to achieve the skills necessary to reach self-sustaining employment? Yes_____ No_____
    If yes, when do you anticipate that your patient will be capable of self-sustaining employment?
    3 months_____ 6 months_____ 1 year_____ more than 1 year_____

Please complete questions 12-17 if your patient is requesting certification of handicapped/ disabled status due to Other Medical Impairment (e.g., Cardiac, Gastrointestinal, Musculoskeletal, Respiratory, Visual,etc.)

12. How many hospital admissions have occurred for this diagnosis/condition in the past 12 months? _____

13. How many hospital admissions have occurred for this diagnosis/condition **prior to** the past 12 months? _____

14. Please provide objective physical examination findings:

15. Please provide any pertinent recent diagnostic test results:

16. Please identify any functional limitations that impair self-sustaining employment:

17. Is the condition static/permanent? Yes_____ No_____
    If no, when do you anticipate that your patient will be capable of self-sustaining employment?
    3 months_____ 6 months_____ 1 year_____ more than 1 year_____

Physician's Signature: _____

Physician's Printed Name: _____

Date: _____