GREAT-WEST FINANCIAL

P.O. Box 17410
Denver, CO 80217-0410
1-866-257-0707 – Tel
1-303-737-2879 – Fax

SUPPLEMENTAL ATTENDING PHYSICIAN'S STATEMENT

NOTE: Great-West assumes no responsibility for any expense incurred in the completion of this statement. When completed, please mail or fax this statement directly to Great-West return form to patient.

Please Print

Name of patient ______________________ Date of birth ____/____/____ (Month / Day / Year)

Patient's address ______________________ (Number, Street, City, State, Zip Code)

1105/1106/104GP
Plan number

I hereby authorize release of information requested on this form, by the below named physician for the purpose of claim processing. Signed (Patient) ______________________

Date ______________

1. History

(a) When did symptoms first appear or accident happen?................................. Mo. _____ Day _____ 20 _____

(b) Date patient ceased work because of disability... Mo. _____ Day _____ 20 _____

(c) Has patient ever had same or similar condition?... ☐ Yes ☐ No If "Yes" state when & describe.

(d) Names and addresses of other treating physicians

2. Diagnosis (including any complications)

(a) Date of last examination.. Mo. _____ Day _____ 20 _____

(b) Diagnosis (including any complications)

(c) If disability due to pregnancy what is expected/was delivery date................ Mo. _____ Day _____ 20 _____

(d) Please describe any complications that would extend this disability longer than for a normal pregnancy.

(e) Subjective symptoms

(f) Objective findings (including current X-ray Reports, EKG's, Laboratory Data and any clinical findings)

3. Dates of Treatment

(a) Date of first visit.. Mo. _____ Day _____ 20 _____

(b) Date of last visit... Mo. _____ Day _____ 20 _____

(c) Frequency.. ☐ Weekly ☐ Monthly ☐ Other (specify)

4. Nature of Treatment (including date and type of surgery and medications prescribed, if any)

5. Progress

(a) Has patient.. ☐ Recovered? ☐ Improved? ☐ Remained unchanged? ☐ Retrogressed?

(b) Is patient.. ☐ Ambulatory? ☐ House confined? ☐ Bed confined? ☐ Hospital confined?

(c) Has patient been hospital confined.................................... ☐ Yes ☐ No If "Yes" give name and address of hospital

____

____

Date of Admission _____/_____/______ Date of Discharge _____/_____/_____

6. Cardiac (if applicable)

(a) Functional capacity .... ☐ Class 1 (No limitation) ☐ Class 2 (Slight limitation)
(American Heart Association) ☐ Class 3 (Marked limitation) ☐ Class 4 (Complete limitation)

(b) Blood pressure (last visit).................... Systolic ______________ /Diastolic ______________

7. Physical Impairment (*as defined in US Dept of Labor Dictionary of Occupations Titles) Please offer your recommendations

- ☐ Class 1 - No limitation of functional capacity; capable of heavy work*.......No restrictions (0-10%)
- ☐ Class 2 - Medium/manual activity*.......(15-30%)
- ☐ Class 3 - Slight limitation of functional capacity; capable of light work*.......(35-55%)
- ☐ Class 4 - Moderate limitation of functional capacity; capable of clerical/administrative (sedentary*) activity.......(60-70%)
- ☐ Class 5 - Severe limitation of functional capacity; incapable of minimal (Sedentary*) activity.......(75-100%)
- ☐ Remarks:

8. Mental/Nervous Impairment (if applicable)

- ☐ Class 1 - Patient is able to function under stress and engage in interpersonal relations (no limitations)
- ☐ Class 2 - Patient is able to function in most stress situations and engage in most interpersonal relations (slight limitations)
- ☐ Class 3 - Patient is able to engage in only limited stress situations and engage in only limited interpersonal relations (moderate limitations)
- ☐ Class 4 - Patient is unable to engage in stress situations or engage in interpersonal relations (marked limitations)
- ☐ Class 5 - Patient has significant loss of psychological, physiological, personal and social adjustment (severe limitations)
- ☐ Remarks:

9. Do you believe the patient is competent to endorse checks and direct the use of the proceeds thereof? ☐ **Yes** ☐ **No**

10. Prognosis

(a) Is patient now totally disabled? ☐ Yes ☐ No

(b) If not now totally disabled, when was patient able to resume his/her regular duties? ☐ Part-time ________/________/________ (Month Day Year) ☐ Full-time ________/________/________ (Month Day Year)

(c) What duties of patient's job is he/she incapable of performing?

____

Do you expect a fundamental or marked change in the future? ☐ Yes ☐ No

(a) If yes, when will patient recover sufficiently to perform his/her regular duties? ☐ 1 mo. ☐ 1-3 mo. ☐ 3-6 mo. ☐ Never

(b) If no, please explain:

____

11. Remarks

____
Name (Attending Physician) / **Please Print**

____
Degree / Specialty

(   ) ______________________________
Telephone

____
Street Address

(   ) ______________________________
Fax

____
City or Town

____
State

____
Zip Code

____
Signature *

____
Date

****Stamp or signature other than physician's own signature will not be accepted.***