Clear Fields

Disability Management Solutions SM
Medical Request Form

CIGNA Group Insurance
Life • Accident • Disability
Life Insurance Company of North America
Connecticut General Life Insurance Company
CIGNA Life Insurance Company of New York

We are evaluating your patient's disability claim. Please respond to the following questions.
Please provide copies of supporting reports, such as office notes/consultations/testing.
(Failure to provide the reports may result in delay in the claim determination).

Claimant Name:	Date of Birth:

What is the primary diagnosis responsible for your patient's impairment that - in your opinion - is preventing return to work?

What is the ICD-9 code for the above diagnosis?	Date of Injury/Illness:	Is this condition work related? ☐ Yes ☐ No

What are the specific additional *(medical/non-medical)* factors impacting return to work, if any?

When did you first treat your patient for this current impairment episode?	Have you treated your patient for this impairment prior to this episode? ☐ Yes ☐ No If yes, when? _____	Date of last visit:	When is your patient's next office visit?

Does treatment plan for this impairment episode include any of the following? *(Please list as appropriate and provide supporting documentation)*

☐ Physical Therapy: _____ ☐ Electrodiagnostic Studies: _____
☐ Surgery: _____ ☐ Imaging Studies: _____
☐ Specialty Referral: _____ ☐ Other: _____

Please list all current medications that are related to this impairment or impact return to work: *(Please include dosage and frequency)*

What are the specific restrictions that you have placed on your patient?

At Work:

At Home *(Activities of Daily Living)*:

Could your patient return to work at this time if accommodations were made for the listed restrictions? ☐ Yes ☐ No

If no, why not?

If no, based on your experience, what is your best estimate of when your patient can return to work?
With Restrictions: _____ Without Restrictions: _____

Physician Name *(Please Print)*:	Degree & Specialty:

Address: *(Street, City, State, Zip Code)*

Telephone Number: ( )	Federal Tax ID #:
Physician Signature:	Date: