



# Mental Health Provider's Statement

The claimant is responsible for completion of this form without expense to the company.

## To Be Completed By Claimant

<b>Personal Data</b>	Name	Social Security Number	Birthdate (MM/DD/YYYY)
	Address (include Number, Street, Town, State, Zip Code)		Telephone Number ( )
	Employer's Name	Occupation	Date Last Worked
	Prescribing Physician		Telephone Number ( )
	Therapist's Name		Telephone Number ( )

## To Be Completed By Provider

<b>Diagnoses</b>	DMV IV CODE	DSM IV MULTIAXIAL DIAGNOSES
	_____	I _____
	_____	II _____
	_____	III _____
		IV _____
	V (Present GAF): (Highest in past Year): (Goal): _____	

<b>Symptom Assessment</b>	Current Disabling Symptoms
	Subjective Symptoms:
	Objective Signs (mental status abnormalities and results of any other diagnostic testing):
Interpersonal Stressors <input type="checkbox"/> No <input type="checkbox"/> Yes, please describe:	Work Stressors <input type="checkbox"/> No <input type="checkbox"/> Yes, please describe:
If there has been a recent hospitalization, indicate where, when and why	

<b>Treatment Plan</b>	Treatment <input type="checkbox"/> Individual Therapy <input type="checkbox"/> Group Therapy <input type="checkbox"/> Medication Management	Date of First Visit	Date of Last Visit
	Is this patient still under your care for this condition? <input type="checkbox"/> No <input type="checkbox"/> Yes, please indicate date service terminated _____		
	Frequency of Visits <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____		
	Shows responsibility in keeping appointments <input type="checkbox"/> Yes <input type="checkbox"/> No, please explain:		
	Goals of Treatment		
Progress Toward Goals			

**To Be Completed By Provider (cont'd)**

**Medication Treatment**

Medication (dose and frequency taken)

- Compliant       Non-Compliant, please explain:  
 Improvement       No Improvement, please explain planned changes:  
 Side Effects:       No       Yes, please identify:

**Competency**

Is this person competent to sign checks and direct the use of the proceeds thereof?     Yes     No

**Functional Abilities**

Please check off the appropriate response of the person's ability to adapt to these specific job situations at this time

	<b>Unlimited</b>	<b>Somewhat Limited</b>	<b>Markedly Limited</b>	<b>Unable to Perform</b>
Follow work rules .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perform repetitive, or short cycle work .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perform at a constant pace .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Maintain attention and concentration .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Perform a variety of duties .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Understand, remember and carry out complex job instructions .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attain set limits and standards .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Relate to co-workers .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interact with supervisors .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Interact with the public/customers .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use judgment and make decisions .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Direct, control or plan activities of others .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Influence people in their opinions, attitudes and judgments ....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Expressing personal feelings .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work alone or apart in physical isolation from others .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What functions of the person's own/usual occupation is the person unable to perform? (Please provide rationale here, if not already provided.)

What functional restrictions have been placed on this person?

**Prognosis**

- What is the person's prognosis for return to own/usual occupation?       Poor     Guarded     Good  
 What is the person's prognosis for return to any occupation?       Poor     Guarded     Good  
 What is the estimated date for return to work? \_\_\_\_\_  
 Could this person benefit from vocational rehabilitation services **at this time**?     Yes     No

**Provider Information**

Name	Specialty	Degree
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Address (include Number, Street, Town, State, Zip Code)	Telephone Number (    )
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**Warning:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant. California Residents: For your protection, California law requires notice of the following: Any person who knowingly and with intent to defraud or deceive any insurance company files a statement of claim containing any materially false, incomplete or misleading information is guilty of a crime and may be subject to fines, confinement in a state prison and substantial civil penalties.  
**Colorado Residents: An insurer or agent who knowingly provides false or misleading information to defraud a claimant regarding insurance proceeds must be reported to the Insurance Division.**

Signature	Date
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