Please fax the completed form to:
Fax Number: 866-411-5613
The Hartford
P.O.Box 14301
Lexington, KY 40512-4301

ATTENDING PHYSICIAN'S STATEMENT - PROGRESS REPORT

THE HARTFORD

To be completed by the Employee

Patient Name:	Date of Birth:	Insured ID Number:
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: ☐ _____ ICD-10 Code: ☐ _____

Secondary condition(s): _____ ICD-9 Code: ☐ _____ ICD-10 Code(s): ☐ _____

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: ☐ Yes ☐ No If "Yes," on what Date(s): _____

Procedure(s): _____ CPT Code(s): _____

Was patient hospitalized since last report? ☐ Yes ☐ No If "Yes," Hospital name and Phone Number: _____

_____ Admission date: _____ Discharge date: _____

Has patient been referred to other physicians? ☐ Yes ☐ No If "Yes," Date of Referral(s): _____

Other Physician Name _____ Phone Number: (___) _____ Specialty: _____

Other Physician Name _____ Phone Number: (___) _____ Specialty: _____

Patient Name: Date of Birth: Insured ID Number:

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		Intermittently with standard breaks	If intermittent circle time for each section below: Hours at one time	Total hours/8 hours
Sit	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8
Stand	☐	or	☐	1 2 3 4 5 6 7 8	1 2 3 4 5 6 7 8
Walk	☐	or	☐	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	☐	☐	☐	☐	
Kneel/crouch	☐	☐	☐	☐	
Climb	☐	☐	☐	☐	
Balance	☐	☐	☐	☐	
Drive	☐	☐	☐	☐	
Lift - Indicate weight in pounds		_____ lbs.	_____ lbs.	_____ lbs.	
Other Restrictions (if any) _____	☐	☐	☐	☐	
Hand Dominance: ☐ Right ☐ Left					
Upper Extremity Activity (not load bearing) Specify right (R) or left (L) if not bilateral					
Fine manipulation (fingering, keyboard)	☐	☐	☐	☐	
Gross manipulation (grip/grasp, handle)	☐	☐	☐	☐	
Reach (extend arms) above shoulder	☐	☐	☐	☐	
Reach (extend arms) below shoulder at desk or workbench level	☐	☐	☐	☐	

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: _____