

Indicate type of claim

A&S/STD/Salary Continuance LTD

Disability Claim Attending Physician Statement

MetLife®

Metropolitan Life Insurance Company
P.O. Box 14590
Lexington, KY 40511-4590
Fax: 1-866-690-1264

Instructions for completing the claim form:

1. Complete all applicable areas of the claim form.
2. Sign the claim form.
3. Fax this form to expedite your claim - retain original for your records.

The following section must be completed and signed by the employee/patient. Any fee for the completion of this form is the patient's responsibility.	Occupation _____
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Name - MUST ANSWER	Social Security # - MUST ANSWER	Employer - MUST ANSWER	Group Report # _____
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I hereby authorize my physician to release any information acquired in the course of my examination or treatment.	Date of Birth _____
Signature of Employee _____ Date _____	

The following section must be completed and signed by the attending physician.
 The purpose of this report is to assist us in making a disability determination. Please complete all applicable sections of this form.
 A MetLife claim representative may telephone your office if additional information is needed.

History

Symptoms result from: Injury Illness Pregnancy If pregnancy, delivery date _____ Expected _____ Actual

Is condition work-related? Yes No Type of delivery _____

Initial date of treatment _____ Most recent date of treatment _____

Did you advise the patient to cease the above noted occupation? Yes No If Yes, Date _____

Names and Phone Numbers of the other providers the patient was referred to:

Name	Phone #	Name	Phone #
_____	_____	_____	_____

Has patient been hospitalized? Yes No If Yes, Date Confined _____ through _____

Name and address of facility _____

Diagnosis and Treatment

Primary ICD-9 _____ . _____ Diagnosis _____

Secondary ICD-9 _____ . _____ Diagnosis _____

Subjective Symptoms _____

Objective Findings (Include copies/results of any x-rays, lab tests, EKG's, MRI's, scans and office notes) _____

Current and Recommended Treatment Plans _____

If surgery performed/anticipated, provide the following:

CPT-4 _____ Procedure _____ Date _____

Medications prescribed (names, dosages) _____



