Prudential

The Prudential Insurance Company of America
Disability Management Services
PO Box 13480, Philadelphia, PA 19176
Tel: 877-367-7781 Fax: 877-889-4885
www.prudential.com/forphysicians

Family & Medical Certification Request for Care of Covered Service Member

Instructions

Employee to fill out employee and Patient/Family Member section and sign
- Documents without the patient's signature will be considered incomplete.

Treating Health Care Provider to fill out physician section and sign
- Documents without the Treating Health Care Provider signature will be considered incomplete.

Remember to make a copy of the completed form for your records.

1 Employee Section

First Name **MI** **Last Name** **Claim Number**

DOB: (MM DD YYYY) Employee ID

2 Patient/Family Member Section

Relationship To Employee: Please check ONLY one

- ☐ Spouse
- ☐ Adult Child
  - ☐ Son
  - ☐ Daughter
- ☐ Parent
- ☐ Next of Kin
- ☐ Other: Explain

Service Member Current Affiliation: Check one

- ☐ Regular Armed Forces
- ☐ National Guard
- ☐ Reserves
- ☐ None of the above: Explain

Veteran's Military Service Information:
Branch:

Rank:

Unit:

Is the service member on the Temporary Disability Retired List (TDRL?)
☐ Yes ☐ No

Is this person on the permanent disability retired list?
☐ Yes ☐ No

Patient First Name MI Patient Last Name

DOB: (MM DD YYYY)

Date Signed (MM DD YYYY)

X

Patient Signature (Explain relationship if other than patient)

By the signature above, I give permission to my health care provider listed below to clarify information previously provided or provide missing information regarding the clinical reason for my family member to take time from work as described within this document. I understand that the required information if not provided in a timely manner, may result in my family member's leave being delayed or denied.

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First Name	MI	Last Name	Claim Number

3 Treating Health Care Provider Section

This section must be filled out by the physician if this application is to be considered complete

Check Medical Condition Classification:

- ☐ (VSI) Very Seriously Ill/Injured (life is in imminently endangered)
- ☐ (SI) Seriously Injured — Cause for immediate concern
- ☐ Other — Deems service member unfit to serve
- ☐ None of the above — Please explain additional information in medical section

Was illness or injury incurred in the line of duty? ☐ Yes ☐ No

Certification Period Start Date (MM DD YYYY)

Certification Period End Date (MM DD YYYY)

☐ Full Day ☐ Partial Day

Multiple or intermittent day absences (List dates below)

Start Date (MM DD YYYY) End Date (MM DD YYYY)

Absence(s) Supported by the Following Clinical Information:
(Please check all that apply)

☐ Single absence of more than 1 day

Start Date (MM DD YYYY)

End Date (MM DD YYYY)

Last Date Worked (MM DD YYYY)

☐ Intermittent /Recurrent/Episodic (List estimated absence need)

Frequency (ex: 2x/week) ☐ x's per ☐ Hour ☐ Day ☐ Week ☐ Month ☐ Year

Duration (ex: 3 hours each) ☐ # ☐ Minutes ☐ Hours ☐ Days ☐ Weeks ☐ Months

Pattern (ex: every Tuesday)

The need for leave meets one or more of the following reasons of "Serious Health Condition". (Please check all that apply)

☐ Inpatient Hospital Care Admission Date (MM DD YYYY) Discharge Date (MM DD YYYY)

- ☐ Permanent Condition Requiring Supervision
- ☐ Absence, Plus Treatment
- ☐ Other: Explain
- ☐ Chronic Condition Requiring Treatment
- ☐ Non Chronic Condition — Requiring Multiple Treatment

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First Name | MI | Last Name | Claim Number

3 Treating Health Care Provider Section (Cont'd.)

This section must be filled out by the physician if this application is to be considered complete

Please check all medical facts below which support the "Serious Health Condition(s)" marked above.

- ☐ Extended periods of incapacitation—actively receiving treatments
- ☐ Extended periods of incapacitation—not receiving active regular treatments
- ☐ Injury/Accident
- ☐ 2 or more treatments by a healthcare provider: If other than yourself, Please list below
- ☐ Therapy—On-going: (PT/Dialysis/Psychological/OT)
- ☐ Other:
- ☐ Prescription Medication: Please list below

NOTE: Routine examinations or directions/medications which may be obtained without treatment from a healthcare provider (ex. aspirin, bed rest) are NOT considered a regimen of treatment.

Please describe care needed by the family member and why the family member must leave work to provide such care:

Physician First Name

Physician Last Name

- ☐ DOD Health Care Provider
- ☐ VA Health Care Provider
- ☐ DOD TRICARE Network Authorized Private Health Care Provider
- ☐ DOD non-network TRICARE Authorized Private Health Care Provider

Physician Area of Specialty (ex: General Practitioner, Oncologist, Obstetrician)

Office Phone Number

Office Fax Number

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First Name	MI	Last Name	Claim Number

Please Read.

GINA Disclaimer: The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Fraud Notice: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive, or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages, and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

I have read and understand all of the terms and conditions of the above fraud notice and disclaimer and also certify that all of the above statements on this form are true.

X

Treating Health Care Provider

Date Signed (MM DD YYYY)

By the signature above, I attest that I am the Treating Health Care Provider to the listed patient. The clinical information I am providing is in regards to the dates of absences listed above. I certify that my patient's family member (employee) must be absent from work or have a modified work schedule due to this condition.

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