DISABILITY CONTINUED MEDICAL TREATMENT FORM

Ohio Public Employees Retirement System
277 East Town Street, Columbus, Ohio 43215-4642
1-800-222-PERS (7377)
www.opers.org

Please complete this form in its entirety. Failure to complete this form in its entirety could result in a delay in processing.

OPERS Disability Standard
For a member to be considered permanently disabled from their last public employment position, the disabling condition must be expected to last for at least 12 months and prevent the member from performing the duties of the member's last public employment position.

STEP 1: Member Personal Information

Social Security Number ___ — ___ — ____ **-OR-** OPERS ID

First Name MI Last Name

Date of Birth ___ / ___ / ____

Gender: ◯ Male ◯ Female

Address

City State ZIP Code

Home Phone Number ___ — ___ — ____

Work Phone Number ___ — ___ — ____

Cell Phone Number ___ — ___ — ____

Preferred Telephone Number for Contact:
◯ Home ◯ Work ◯ Cell

Preferred Time to Call:
◯ Morning ◯ Afternoon ◯ Evening

E-mail Address

See next page

STEP 2: Member's Acknowledgment

HIPAA DISCLOSURE:

I authorize any licensed physician, medical provider, medical facility or provider of health care or similar entity to release any and all of the following information to OPERS or its third party administrators. I understand if there are any expenses for releasing this information it is my responsibility to pay those expenses.

Medical information with respect to any physical or mental condition and/or treatment of me, including confidential information regarding AIDS/HIV infection, communicable diseases, alcohol and substance abuse, and mental health.

I understand the information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim benefits, return to employment opportunities, and assessment of ongoing treatment. Any information obtained will not be released to any person or organization except OPERS and their third party administrators.

I agree that a photographic copy of this Authorization shall be as valid as the original.

I understand that I may request a copy of this Authorization. This Authorization shall become effective on the date appearing next to my signature below.

I understand I have the right to revoke this Authorization at any time by notifying OPERS.

I understand that revoking this Authorization may impair necessary processing of my OPERS benefits.

Member Signature _____ Today's Date ____/____/____

Do not print or type name

See next page

STEP 3: Attending Physician Information - *must be completed by the member's attending physician who is a licensed and practicing MD or DO.*

Physician Name MD DO

Specialty

Board Certified (ABMS): Yes No Sub-certification (if applicable): Yes No

Physician Office Mailing Address

City State ZIP Code

Physician Office Phone Number Fax Number

Physician E-mail Address

Primary Office Contact

Primary Office Contact Phone Number Fax Number

Primary Office Contact E-mail Address

Office Hours: _____ Preferred Time to Call: _____

Preferred Telephone Method f Contact: Phone Fax E-mail

Secondary Office Contact

Secondary Office Contact Phone Number Fax Number

Secondary Office Contact E-mail Address

See next page

STEP 4: Patient Information - *must be completed by the member's attending physician who is a licensed and practicing MD or DO.*

Treated Member From: ___ ___ / ___ ___ / ___ ___ ___ ___ To: ___ ___ / ___ ___ / ___ ___ ___ ___

Frequency of Office Visits for Disabling Condition(s): ◯ Monthly ◯ Qtr. ◯ Semi-ann. ◯ Ann. ◯ Other

Date of Last Office Visit for the Disabling Condition(s): ___ ___ / ___ ___ / ___ ___ ___ ___

Do you have knowledge that the claimant/patient is receiving Workers' Compensation benefits for this disabling condition(s)?

◯ Yes ◯ No ◯ I do not know

Are you the doctor of record for the Bureau of Workers' Compensation claim?

◯ Yes ◯ No ◯ N/A

STEP 5: Physician's Findings - *must be completed by the member's attending physician who is a licensed and practicing MD or DO.*

Please include any test results that enabled you to make your diagnosis(es).

DISABLING CONDITION(S):
A member is considered eligible for a disability benefit if the disabling condition prevents the performance of duties for their last employment and the disabling condition is expected to last at least 12 months.

1) Primary Disabling Condition

2) Secondary Condition(s) Impacting the Primary Disabling Condition:

3) Member Complaints:

4) Member Symptoms:

5) Current Medications:

See next page

STEP 5: Physician's Findings (continued) - *must be completed by the member's attending physician who is a licensed and practicing MD or DO.*

Please include any test results that enabled you to make your diagnosis(es).

6) Laboratory and/or Diagnostic Findings:

Physician Reported Member Job Restrictions and/or Limitations Form *Max = Maximum lifting/carrying/pushing/pulling capacity - (lbs.)					
Address all below if applicable:	Max*	Not Applicable	**Occasional** 0-2.6 hrs/day	**Frequent** 2.7-5.3 hrs/day	**Constant** 5.4-8 hrs/day
Low Lift (floor to knuckle)		◯	◯	◯	◯
Mid Lift (knuckle to shoulder)		◯	◯	◯	◯
Full Lift (floor to shoulder)		◯	◯	◯	◯
Carrying		◯	◯	◯	◯
Pushing		◯	◯	◯	◯
Walking	N/A	◯	◯	◯	◯
Climbing	N/A	◯	◯	◯	◯
Balance	N/A	◯	◯	◯	◯
Stoop	N/A	◯	◯	◯	◯
Kneeling	N/A	◯	◯	◯	◯
Crouching	N/A	◯	◯	◯	◯
Crawling	N/A	◯	◯	◯	◯
Reaching (immediate)	N/A	◯	◯	◯	◯
Reaching (overhead)	N/A	◯	◯	◯	◯
Handling	N/A	◯	◯	◯	◯
Fingering	N/A	◯	◯	◯	◯
Feeling	N/A	◯	◯	◯	◯
Sitting	N/A	◯	◯	◯	◯
Standing	N/A	◯	◯	◯	◯

See next page

STEP 6: Continued Medical Treatment - *must be completed by the member's attending physician who is a licensed and practicing MD or DO.*

Please include any test results that enabled you to make your diagnosis(es).

1) Historical Treatment/Care Plan:

2) Current Treatment/Care Plan:

3) Has member complied with Current Treatment/Care Plan? ◯ Yes ◯ No

4) Has member shown medical improvement with Current Treatment/Care Plan? ◯ Yes ◯ No

If yes, indicate level of improvement: ◯ Fair ◯ Moderate ◯ Good ◯ Excellent

5) Prognosis for recovery from disabling condition(s):

See next page

STEP 7: Physician's Determination - *must be completed by the member's attending physician who is a licensed and practicing MD or DO.*

For a member to be permanently disabled from his last public employment position, the disabling condition must be expected to last for at least 12 months and prevent the member from performing the duties of the member's last public employment position.

Do you consider this member to be permanently disabled from their last public employment position as described above? ◯ Yes ◯ No

If you selected NO, what is the expected date the member could return to their public employment position? ___/___/____

If you selected NO, could the member return to work with restrictions and/or limitations? ◯ Yes ◯ No

If yes, please describe:

Physician's Name:

Physician's Signature _____ Today's Date ___/___/____
Do not print or type name

Physician's Medical Title: MD ☐ DO ☐


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