REPORT OF PHYSICIAN

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. Managed Medical Review Organization (MMRO), OPERS' third party administrator, may be contacting you regarding this member.

STEP 1: Member's 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 Authorization and 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 its 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 application.

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 of Contact: ◯ Phone ◯ Fax ◯ E-mail

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 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).

1) Member Complaints:

2) Member Symptoms:

3) Current Medications:

4) Laboratory and/or Diagnostic Findings:

See next page

STEP 5: Physician 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).

5) Historical Treatment/Care Plan:

6) Current Treatment/Care Plan:

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

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

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

See next page

STEP 5: Physician 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).

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: Physician 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 his last public employment position. Disability coverage does not extend to illness or injuries resulting from elective cosmetic surgery other than reconstructive surgery. Please include any test results that enabled you to make your diagnosis(es).

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

IF YES, complete below:

What is the member's Primary Disabling Condition?

Corresponding ICD Code:

Date on which illness or injury occurred: __ __ / __ __ / __ __ __ __

Date on which illness or injury became permanently disabling: __ __ / __ __ / __ __ __ __

Has the member's condition progressed since the illness or injury occurred? ◯ Yes ◯ No

IF NO, complete below:

What is the expected date the member could return to their public employment position? __ __ / __ __ / __ __ __ __

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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