



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. In order for this form to be accepted, please submit the last 12 months of medical records. Failure to complete this form in its entirety could result in a delay in processing. OPERS' third-party administrator may be contacting you regarding this member.

STEP 1: Member's Personal Information

Social Security Number

OPERS ID

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-OR-

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First Name

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Last Name

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Date of Birth

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Gender: Male Female

Address

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City

State

ZIP Code

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Home Phone Number

Work Phone Number

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Cell Phone Number

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Preferred Telephone Number for Contact:

Preferred Time to Call:

Home Work Cell

Morning Afternoon Evening

E-mail Address

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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: 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 if there are any expenses for releasing this information it is my responsibility to pay those expenses.

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

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

Grid for Physician Name (26 columns) and MD/DO (2 columns)

Specialty

Grid for Specialty (26 columns)

Board Certified (ABMS): Yes No

Sub-certification (if applicable): Yes No

Physician Office Mailing Address

Grid for Physician Office Mailing Address (26 columns)

City

State

ZIP Code

Grid for City (15 columns), State (2 columns), and ZIP Code (5 columns)

Physician Office Phone Number

Fax Number

Grid for Physician Office Phone Number (12 columns) and Fax Number (12 columns)

Physician E-mail Address

Grid for Physician E-mail Address (26 columns)

Primary Office Contact

Grid for Primary Office Contact (26 columns)

Primary Office Contact Phone Number

Fax Number

Grid for Primary Office Contact Phone Number (12 columns) and Fax Number (12 columns)

Primary Office Contact E-mail Address

Grid for Primary Office Contact E-mail Address (26 columns)

Office Hours: _____ Preferred Time to Call: _____

Preferred Telephone Method of Contact: Phone Fax E-mail

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 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 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 their 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:

Date on which illness or injury occurred: / /

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 _____

Do not print or type name

Today's Date _____ / _____ / _____

Physician's Medical Title

MD DO

STEP 6: Physician Findings - must be completed by the member's attending physician who is a licensed and practicing MD or DO. PLEASE ATTACH ALL MEDICAL AND/OR PSYCHOLOGICAL RECORDS WITHIN THE LAST 12 MONTHS, INCLUDING OFFICE NOTES, CLINIC AND ER VISITS, LABS, ALL TEST RESULTS AND DISCHARGE SUMMARIES. PLEASE NOTE – UNABLE TO ACCEPT DIGITAL MEDIA, ONLY INCLUDE REPORT FINDINGS.

Please complete each applicable section based on the disabling condition. The medical data provided by you in the report (clinical findings, diagnosis, test results) will be used to adjudicate the disability determination process.

PART I – Medical Information

(For disabling psychological conditions only, proceed to Part II.)

(If no disabling psychological conditions, proceed to Part III upon completion.)

CURRENT MEDICATIONS

CURRENT MEDICATIONS

MEDICAL HISTORY

[Include hospitalizations within the past five years. (List facilities, dates and reasons for admission(s))]

MEDICAL HISTORY

PHYSICAL EXAMINATION

Complete the following section **only** providing information that is related to the disabling condition(s).

Temperature:	Blood Pressure:	Height:	Weight:	Pulse:	Respiratory Rate:

General appearance:

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VISION

[For example: Ophthalmological changes, cataract(s); glaucoma; macular problems; diabetic retinopathy; Certificate of Blindness; best corrected visual acuity; visual field testing]

VISION

HEARING

[For example: Whispered/spoken word; cochlear implant; Other amplification devices; Use of American Sign Language (ASL); Audiological Evaluation (including audiogram); vestibular testing; electronystagmography (ENG)]

HEARING

RESPIRATORY SYSTEM

[For example: Pulmonary function; lung function (wheezes, rhonchi, or rales); cyanosis/dyspnea; chest x-ray report; pulmonary function test; arterial/gas studies; in the case of pulmonary tuberculosis, provide sputum culture results]

CARDIOVASCULAR SYSTEM

[For example: Blood pressure readings; indication of chest pain; edema, pigmentation, cyanosis or ulceration; end-organ damage as result of hypertension; indicate New York Heart Classification; chest x-ray report; electrocardiogram (EKG) report; echocardiogram (ECHO) report; Exercise Tolerance Test]

DIGESTIVE SYSTEM

[For example: Weight loss; liver studies; x-ray report; endoscopy; colonoscopy; pathology]

GENITOURINARY SYSTEM

[For example: Report of dialysis treatment; history of transplant; BUN; Creatine Clearance]

HEMATOLOGICAL SYSTEM

[For example: Indication of the following: anemias, bone marrow disorders, etc.; blood transfusions; stem cell transplant; complete blood count]

SKIN

[For example: Extent of lesions and part of body system impacted; if burn(s), total body surface area involvement; other pertinent findings if critical areas of the body are involved (such as palms of hands and soles of feet); biopsy; pathology]

ENDOCRINE SYSTEM

[For example: Diabetes; evidence of neuropathy; acidosis; amputations; ophthalmological changes; lab studies]

MUSCULOSKELETAL SYSTEM

[For example: Limitation of motion and the degree; comment on history of pain, swelling, and stiffness; MRI report; x-ray report; ESR/RF studies]

NEUROLOGICAL SYSTEM

[For example: Reflexes; motor strength; sensation (light touch, pin prick, vibration and position); cranial nerves; cerebellar function (include observed ambulation); mental status (i.e., oriented X3, confused, etc.); electromyography (EMG); nerve conduction study (NCS); electroencephalogram (EEG)]

MALIGNANT NEOPLASMS

[For example: Type, extent and site of the primary recurrent or metastatic lesion; treatment plan and prognosis; operative procedures including biopsy or needle aspiration; operative note or pathology report]

IMMUNE SYSTEM

[For example: Indication of the following: autoimmune disorder(s) (such as Lupus), immunodeficiency disorder(s) (primary or acquired), HIV infection, etc.; any constitutional symptoms such as fatigue, fever, malaise, etc.; blood studies; angiography; x-ray; CAT scan report; MRI report]

OTHER

[Please indicate any other pertinent physical examination findings and/or laboratory/diagnostic studies not listed above.]

Part II – Psychological Information

(If no disabling psychological conditions, proceed to Part III.)

CURRENT MEDICATIONS

PSYCHIATRIC HISTORY

[Include hospitalizations within the past five years. (List facilities, dates and reasons for admission(s).)]

MENTAL STATUS ASSESSMENT

Complete the following section **only** providing information that is related to the disabling condition(s).
(If no psychological conditions, proceed to Part III.)

Current clinical signs and symptoms that support the diagnosis(es) (sleep, interest, guilt, energy, concentration, appetite, psychomotor, suicidal ideation, etc.)

APPEARANCE/ATTITUDE/BEHAVIOR

[For example: Personal hygiene and grooming]

ORIENTATION

[For example: Person, date, place]

MOOD AND AFFECT

[For example: Labile, blunt, flat]

SPEECH

[For example: Pressured, paucity of speech, etc.]

THOUGHT PROCESS

[For example: Dissociation, blocking, flight of ideas, etc.]

THOUGHT CONTENT

[For example: Phobias, obsessions, delusions, ideas of reference, etc.]

PERCEPTIONS

[For example: Hallucinations – auditory or visual]

COGNITION

[For example: Impairment of memory, judgment/ability to perform calculations, level of intellectual function, ability to concentrate and/or learn]

SOCIAL

[For example: Ability to interact with others or those in a position of authority]

OTHER

[Please indicate any other pertinent clinical findings not listed above and/or results of neuropsychiatric testing.]

Part III – Treatment and Prognosis

HISTORICAL TREATMENT
(E.G. SUCCESSFUL AND FAILED TREATMENTS):

CURRENT TREATMENT

Has member shown medical improvement with Current Treatment? Yes No

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

PROGNOSIS FOR RECOVERY FROM DISABLING CONDITION(S)