OPERS

Ohio Public Employees Retirement System

277 East Town Street, Columbus, Ohio 43215-4642

1-800-222-PERS (7377) www.opers.org

Report of Physician

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.

OPERS Disability Standard

For a member to be considered 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.

Section 1 - Member's Personal Information

Social Security Number

Gender Male ☐ Female ☐

Date of Birth Month Day Year

First Name **MI** **Last Name** **Suffix**

Street or Mailing Address **Apt. Number**

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

Section 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.

Today's Date

Month **Day** **Year**

Member Signature_____

Do not print or type name

Sections 3, 4, 5 and 6 of this form must be completed by a physician on the member's behalf. The physician must be a licensed and practicing MD or DO.

Section 3 - Physician Information - *It is important to provide contact information.*

Physician Name **MD** ☐ **DO** ☐

Specialty

Board Certified (ABMS)? Y ☐ **N** ☐ **Sub-Certification (if applicable) Yes** ☐ **No** ☐

Physician Office Mailing Address **Suite Number**

City **State** **ZIP Code** –

Physician Office Phone Number **Physician Fax Number**

Physician E-mail Address

Primary Office Contact

Primary Office Contact Phone Number **Primary Office Contact Fax Number**

Primary Office Contact E-mail Address

Office Hours: _____ **Preferred Time to Call:** _____

Preferred Method of Contact: Phone ☐ **Fax** ☐ **E-mail** ☐

Section 4 - Patient Information

Time Treating Member **From:** **Month** **Day** **Year** **To:** **Month** **Day** **Year**

Frequency of Office Visits for Disabling Condition(s) Monthly ☐ **Qtr** ☐ **Semi-Ann** ☐ **Ann** ☐ **Other** ☐ _____

Date of Last Office Visit for the Disabling Condition(s) **Month** **Day** **Year**

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

Yes ☐ **No** ☐ **or, I do not know** ☐

If there is a Bureau of Workers' Compensation claim, are you the doctor of record? Yes ☐ **No** ☐

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Section 5 - Physician Findings - *Please include any test results that enabled you to make your diagnosis(es).*

1) Member Complaints:

2) Member Symptoms:

3) Current Medications:

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Section 5 - Physician Findings *(continued)* - *Please include any test results that enabled you to make your diagnosis(es).*

4) Laboratory and/or Diagnostic Findings:

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): _____

_____

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Section 5 - Physician Findings *(continued)* - *Please include any test results that enabled you to make your diagnosis(es).*

Physician Reported Member Job Restrictions and/or Limitations

**Max = Maximum lifting/carrying/pushing/pulling capacity - (lbs.)*

Please address all below if applicable:	Max*	Not Applicable	Occasional 0 to 2.6 hours/day	Frequent 2.7 to 5.3 hours/ day	Constant 5.4 to 8 hours/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	☐	☐	☐	☐

Sections 3, 4, 5 and 6 of this form must be completed by a physician on the member's behalf. The physician must be a licensed and practicing MD or DO.

Section 6 - Physician's Determination *- Please include any test results that enabled you to make your diagnosis(es).*

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.

Do you consider this member to be permanently disabled from his last public employment position?

IF YES, PLEASE COMPLETE THE FOLLOWING INFORMATION AND SIGN AND DATE BELOW.

IF NO, SKIP TO PAGE 8 AND COMPLETE THE INFORMATION ON THAT PAGE, AND SIGN AND DATE.

☐ **YES, I consider this member permanently disabled from his last public employment position.**

Primary Disabling Condition: _____

Corresponding ICD Code: ☐☐☐☐☐

Date on which illness or injury occurred: Month ☐☐ Day ☐☐ Year ☐☐☐☐

Date on which illness or injury became permanently disabling: Month ☐☐ Day ☐☐ Year ☐☐☐☐

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

Physician's Name:

First Name ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ **MI** ☐ **Last Name** ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Today's Date

Physician's Signature _____ Month ☐☐ Day ☐☐ Year ☐☐☐☐

Do not print or type name

Physician's Medical Title _____ **MD** ☐ **DO** ☐

Sections 3, 4, 5 and 6 of this form must be completed by a physician on the member's behalf. The physician must be a licensed and practicing MD or DO.

Section 6 - Physician's Determination *(continued)* - *Please include any test results that enabled you to make your diagnosis(es).*

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 his last public employment position. Disability coverage does not extend to illness or injuries resulting from elective cosmetic surgery other than reconstructive surgery.

Do you consider this member to be permanently disabled from his last public employment position?

☐ **NO, I do not consider this member permanently disabled from his last public employment position.**

What is the expected date the member could return to their public employment position? **Month** ☐☐ **Day** ☐☐ **Year** ☐☐☐☐

If the member returns to work, are there restrictions and/or limitations? **Yes** ☐ **No** ☐

If yes, please describe:

Physician's Name:

First Name **MI** **Last Name**

Today's Date

Month ☐☐ **Day** ☐☐ **Year** ☐☐☐☐

Physician's Signature _____

Do not print or type name

Physician's Medical Title _____ **MD** ☐ **DO** ☐

OPERS

MMro Managed Medical Review Organization

URAC ACCREDITED INDEPENDENT REVIEW ORGANIZATION: COMPREHENSIVE