



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 along with the last 6 months of medical records. 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's Personal Information

Social Security Number

OPERS ID

-OR-

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

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 benefits.

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 entering physician name.

Grid for entering MD or DO designation.

Specialty

Grid for entering specialty.

Board Certified (ABMS): Yes No

Sub-certification (if applicable): Yes No

Physician Office Mailing Address

Grid for entering mailing address.

City

State

ZIP Code

Grid for entering city.

Grid for entering state.

Grid for entering ZIP code.

Physician Office Phone Number

Fax Number

Grid for entering physician office phone number.

Grid for entering fax number.

Physician E-mail Address

Grid for entering physician e-mail address.

Primary Office Contact

Grid for entering primary office contact name.

Primary Office Contact Phone Number

Fax Number

Grid for entering primary office contact phone number.

Grid for entering primary office contact fax number.

Primary Office Contact E-mail Address

Grid for entering primary office contact e-mail address.

Office Hours: _____

Preferred Time to Call: _____

Preferred Telephone Method of Contact: Phone Fax E-mail

Secondary Office Contact

Grid for entering secondary office contact name.

Secondary Office Contact Phone Number

Fax Number

Grid for entering secondary office contact phone number.

Grid for entering secondary office contact fax number.

Secondary Office Contact E-mail Address

Grid for entering secondary office contact e-mail address.

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 the member's last public employment position.

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

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 6 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.)

PRIMARY DISABLING CONDITION

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CURRENT MEDICATIONS

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MEDICAL HISTORY

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

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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:
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General appearance:

VISION

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

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)]

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.]

STEP 7: 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).

Part III – Treatment and Prognosis

HISTORICAL TREATMENT

[For example: Successful and failed treatments]

CURRENT TREATMENT

Has member complied with current treatment? Yes No

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)