OPERS

# Ohio Public Employees Retirement System

277 East Town Street, Columbus, Ohio 43215-4642

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

# Disability Continued Medical Treatment Form

***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 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.

## 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 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.

**Today's Date**

**Month** **Day** **Year**

Member Signature_____ | | | | | | | | |

Do not print or type name

**Sections 3, 4, 5, 6 and 7 of this form must be completed by the member's attending physician. The physician must be a licensed and practicing MD or DO.**

## Section 3 - Attending 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** ☐

**Secondary Office Contact**

**Secondary Office Contact Phone Number** **Secondary Office Contact Fax Number**

**Secondary Office Contact E-mail Address**

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

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

**Sections 3, 4, 5, 6 and 7 of this form must be completed by the member's attending physician. The physician must be a licensed and practicing MD or DO.**

## 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** ☐

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

**DISABLING CONDITION(S):** *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.*

**1) Primary Disabling Condition:**

**1.** _____

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

**1.** _____

**2.** _____

**3) Member Complaints:**

**4) Member Symptoms:**

**5) Current Medications:**

**Sections 3, 4, 5, 6 and 7 of this form must be completed by the member's attending physician. The physician must be a licensed and practicing MD or DO.**

## Section 5 - Physician Findings *(continued)* - *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.)*

| *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, 6 and 7 of this form must be completed by the member's attending physician. The physician must be a licensed and practicing MD or DO.**

## Section 6 - Continued Medical Treatment *- 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): _____**

_____

**Sections 3, 4, 5, 6 and 7 of this form must be completed by the member's attending physician. The physician must be a licensed and practicing MD or DO.**

## Section 7 - Physician's Determination

**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?**

☐ **YES, I consider this member permanently disabled as described above.**

☐ **NO, I do not consider this member permanently disabled as described above.**

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

**Month** **Day** **Year**

**If you selected NO, could the member return to work with 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