Short Term Disability Claim Form
Physician Statement

Anthem Life

Anthem Life Insurance Company
Disability Claims Service Center
PO Box 105426
Atlanta, GA 30348-5426
Phone: 800-813-5682 Fax: 800-850-0017
Email: lifeanddisabilityclaims@anthem.com

SECTION 3: TO BE COMPLETED BY PHYSICIAN

Note to Physician: Completion of this form will assist your patient in presenting a claim for disability benefits. Please complete all areas of the form; if a section is non-applicable, please enter N/A in the response area.

Patient name (last, first, M.I.)			Birthdate (MM/DD/YYYY)
Current diagnosis		ICD-9 code/DSM IV	
Subjective complaints		Objective findings	
Has patient ever had same or similar condition? ☐ Yes ☐ No	If yes, please specify dates of treatment	Did injury or illness arise out of or in course of employment for wages or profit? ☐ Yes ☐ No ☐ Unknown If yes, please explain: _____	
Is disability due to pregnancy? ☐ Yes ☐ No	If yes, LMP (MM/DD/YYYY)	EDC (MM/DD/YYYY)	Type of delivery ☐ Vaginal ☐ C-section
Was patient hospitalized? ☐ Yes ☐ No	If yes, please provide date of confinement	Name of hospital/facility	
Nature of surgical procedure, if any. Describe in full (Add additional sheets if necessary).			Date performed (MM/DD/YYYY)
Date patient first unable to work	Date of first visit	Date of last visit	Patient's present condition
Frequency of visits ☐ Weekly ☐ Monthly ☐ Other: _____		Treatment plan	
Functional impairments		Current medications and dosages	
Patient released to return to work? ☐ Yes ☐ No If yes: ☐ Full-time, no restrictions ☐ Light duty (Please specify restrictions, limitations, hours, graduated return to work schedule, etc.)		Date able to return to full duty	Date able to return to light duty
Is this patient a suitable candidate for a rehabilitation program? ☐ Yes ☐ No		Is this patient competent to endorse checks and direct the proceeds thereof? ☐ Yes ☐ No	
Physician printed name			Physician specialty
Physician street address		City	State / ZIP code
Physician phone no.	Physician fax no.	Physician email address	
Signature of physician **X**			Date (MM/DD/YYYY)

Si usted necesita ayuda en Español para entender este documento, puede solicitarlo sin ningun costo adicional llamando al número de servicio al cliente que se encuentra en este documento.