Reset

Standard Insurance Company

Benefits Department
PO Box 2800 Portland OR 97208 855.977.7764 Tel

Stay At Work
Medical Information Request

Dear Employee: Please complete this section.

Employee Name _____ Birth Date _____

Employer _____

Dear Provider: We are currently working with your patient to assist him/her by understanding their limitations and restrictions in order to provide the right accommodations that will allow him/her to successfully remain at work. ***Please include results of diagnostic testing and pertinent chart notes.***

1. Diagnosis (include the ICD code)_____

Date of most recent visit_____ Frequency of visits _____

Expected duration of impairment from this condition _____

2. Describe your patient's current symptoms: _____

3. What are your patient's work limitations and restrictions? _____

4. Planned course of treatment (include expected duration):_____

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false, or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

Physician's Signature		Date	
Physician's Name (please print)		Specialty	
Address	City	State	ZIP
Phone No.	Fax No.		

Please fax completed form to: 971-321-5727/855-207-6115

Print