

# Standard Insurance Company

Benefits Department  
PO Box 2800 Portland OR 97208 855.977.7764 Tel



**PEBA**  
SC Retirement Systems  
and State Health Plan

## Stay at Work Medical Information Request

### Employee, complete this section.

Employee name \_\_\_\_\_ Date of birth \_\_\_\_\_  
Employer \_\_\_\_\_

**Provider: To help us provide the right accommodations for your patient to remain at work, we need to know your patient's limitations and restrictions. 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 might be deemed a felony and substantial fines could 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 The Standard at 971.321.5727 or 855.207.6115**