

Disability Management SolutionsSM
Follow-Up Medical Request Form

CIGNA Group Insurance
 Life • Accident • Disability
 Life Insurance Company of North America
 Connecticut General Life Insurance Company
 CIGNA Life Insurance Company of New York



We are continuing to evaluate your patient's disability claim. Please respond to the following questions.
 Attached is a Department of Labor description of your patient's occupation for your reference.

Please document your medical findings by providing copies of supporting reports, such as office notes/consultations/testing.
(Failure to provide the requested reports may result in delay in the claim determination).

Claimant Name:		Date of Birth:
How has the patient's condition changed since the last update? <input type="checkbox"/> No change <input type="checkbox"/> Improved <input type="checkbox"/> Worse		
Date of your patient's last office visit:	When is your patient's next office visit?	
Please list any change in the treatment plan since the last update:		
Please list all current medications that are related to this impairment or impact return to work:		
What are the specific restrictions that you have placed on your patient at this time? At Work: At Home <i>(Activities of Daily Living)</i> :		
Do you expect functional deficits to prevent your patient from performing essential job functions? <input type="checkbox"/> Yes <input type="checkbox"/> No Please specify:		
Could your patient return to work at this time if accommodations were made for the listed restrictions? <input type="checkbox"/> Yes <input type="checkbox"/> No If no, why not? If no, based on your experience, what is your best estimate of when your patient can return to work? With Restrictions: _____ Without Restrictions: _____		
Physician Name <i>(Please Print)</i> :	Degree & Specialty:	
Address: <i>(Street, City, State, Zip Code)</i>		
Telephone Number: ()	Federal Tax ID #:	
Physician Signature:	Date:	