# Cigna Leave Solutions®
# Certification of Health Care Provider for Employee's Serious Health Condition

**Date Prepared:** _____

**Must be returned by:** _____

**Employee name:** _____

**Employer name:** _____

**Leave ID:** _____

**Reason for requesting leave:** _____

**Leave date(s)/Period(s) requested:** _____

**SECTION I: For Completion by the EMPLOYEE:**

**INSTRUCTIONS to the EMPLOYEE:** Please complete Section I before giving this form to your medical provider. The FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. If requested by your employer, your response is required to obtain or retain the benefit of FMLA protections. 29 U.S.C. §§ 2613, 2614(c)(3). Failure to provide a complete and sufficient medical certification may result in a denial of your FMLA request. 29 C.F.R. § 825.313. Your employer must give you at least 15 calendar days to return this form. 29 C.F.R. § 825.305(b). If your certification is returned incomplete or insufficient, your employer must give you at least 7 calendar days to cure any deficiency. 29 C.F.R. § 825.305(c).

The Genetic Information Nondiscrimination Act of 2008 (GINA), and, where applicable, the California Genetic Information Nondiscrimination Act of 2011 (CalGINA), prohibits employers and other entities covered by GINA Title II, and where applicable CalGINA, from requesting or requiring genetic information of employees or their family members, except as specifically allowed by law. In order to comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information, unless failing to provide the information will result in an incomplete or insufficient certification. **(If the employee is seeking leave under the District of Columbia Family and Medical Leave Act, genetic information should not be provided under any circumstance.)** 'Genetic information,' as defined by GINA, includes an individual's family member medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services. "Genetic Information," as defined by CalGINA, includes information about the individual's or the individual's family member's genetic tests, information regarding the manifestation of a disease or disorder in a family member of the individual, and includes information from genetic services or participation in clinical research that includes genetic services by an individual or any family member of the individual. "Genetic Information" does not include information about an individual's sex or age.

*PLEASE BE SURE TO RETURN ALL PAGES

Employee job Title: _____ Regular Work Schedule: _____

_____ _____

**Employee Signature** **Date**

**See reverse to provide additional information**

**SECTION II: For Completion by the HEALTH CARE PROVIDER:**

**INSTRUCTIONS to the HEALTH CARE PROVIDER:** Your patient has requested leave under the FMLA. Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "**lifetime,**" "**unknown,**" or "**indeterminate**" may not be sufficient to determine FMLA coverage. Limit your responses to the condition for which the employee is seeking leave. Please be sure to sign the form on the last page.

**Subsection A: Must be completed for ALL types of leaves:**

1. Provider's name: _____ Phone # _____ Fax # _____
   Address: _____
   Type of practice / Medical specialty: _____

**Please complete the following:**

2. Approximate date the condition commenced: _____ Probable Duration of condition: _____
3. Date(s) you treated the patient for condition in the past 12 months: _____
4. Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility?
   ☐ Yes ☐ No If yes, dates of admission in the past 12 months: _____
5. Will the patient need treatment visits at least twice per year due to the condition? ☐ Yes ☐ No
6. Was medication, other than over-the-counter medication, prescribed? ☐ Yes ☐ No
7. Is the medical condition pregnancy? ☐ Yes ☐ No If yes, expected delivery date: _____
8. Will the condition cause episodic flare-ups periodically preventing the employee from performing his/her job functions? ☐ Yes ☐ No If yes, explain _____
9. Is the employee unable to perform any of his/her job functions due to the condition based on the employee's own description of his/her job? ☐ Yes ☐ No
   If yes, identify the job functions the employee is unable to perform: _____
10. Describe other relevant medical facts, if any, related to the condition for which the employee seeks leave (such medical facts may include symptoms, diagnosis, including x-rays or diagnostic testing, or any regimen of continuing treatment such as the use of specialized equipment) **(Note: If the employee is requesting leave under the California Family Rights Act or the Connecticut Family and Medical Leave Act, do not include diagnosis information):**
    _____
    _____

**Subsection B: Must be completed for all CONTINUOUS LEAVES:**

1. Will the employee be incapacitated for a **single continuous period of time** due to his/her medical condition, including any time for treatment and recover? ☐ Yes ☐ No

If yes, estimate the beginning and ending dates for the period of incapacity:

Start Date: _____ End Date: _____

**(Form is considered incomplete/insufficient if not provided for a continuous leave)**

**Subsection C: Must be completed for all REDUCED SCHEDULED LEAVES:**

1. Is it **medically necessary** for the employee to work part-time or a reduced schedule because of the employee's condition? (this includes follow up treatment appointments) ☐ Yes ☐ No

If yes, estimate the the part-time or reduced work schedule the employee needs:

_____ hour(s) per day _____ time(s) per week _____ time(s) per month

Start Date: _____ End Date: _____

**(Form is considered incomplete/insufficient if not provided for a reduced/part time leave)**

**Subsection D: Must be completed for all INTERMITTENT LEAVES:**

1. Will the employee need intermittent time off, ☐ Yes ☐ No if yes, estimate the beginning and ending dates for the period the patient needs to be out of work: Start Date: _____ End Date: _____

2. **OFFICE VISITS/TREATMENTS:**
   Based upon the patient's medical history and your knowledge of the medical condition, estimate the maximum frequency of follow-up treatments/office visits that employee would need off work for related incapacity that the employee may experience over the next 6 months.
   (e.g., Duration: _____3_____ hours per visit/treatment
   Frequency: ____3____ times per __1__ ☐ week(s) / ☒ month(s) (check one))
   Duration: _____ hours per visit/treatment
   Frequency: _____ times per _____ ☐ week(s) / ☐ month(s) (check one)
   **(Form is considered incomplete/insufficient if not provided for a continuous leave)**

3. **INCAPACITY:**
   Based upon the patient's medical history and your knowledge of the medical condition, estimate the maximum frequency of incapacity that employee would need off work over the next 6 months.
   (e.g., Duration: _____3_____ hours per visit/treatment
   Frequency: ____3____ times per __1__ ☐ week(s) / ☒ month(s) (check one))
   Duration: _____ hours per visit/treatment
   Frequency: _____ times per _____ ☐ week(s) / ☐ month(s) (check one)
   **(Form is considered incomplete/insufficient if not provided for an intermittent leave)**

**ADDITIONAL INFORMATION:**

_____

_____

_____ _____

**Signature of Health Care Provider** **Date**

**PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT**

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. § 2616; 29 C.F.R § 825.500. The U.S. Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for review instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION.**

*Return completed form to:*

**Cigna Leave Solutions® P.O. Box 16163 Pittsburgh, PA 15242-0791**

**Fax: 866.931.5095**

**Email: FMLACertifications@Cigna.com**

# AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

**NOTE: This authorization is designed to comply with HIPAA and relates to information necessary to administer coverage and services under your employer's employee health and welfare plan(s) ("the Plan") and similar or coordinating governmental benefits.**

**COMPLETING THIS AUTHORIZATION IS NOT REQUIRED FOR LEAVE UNDER THE FAMILY AND MEDICAL LEAVE ACT, OR STATE LEAVES OR COMPANY LEAVE PLANS ADMINISTERED BY CIGNA LEAVE SOLUTIONS. HOWEVER, IF YOU FAIL TO PROVIDE A VALID AND COMPLETE CERIFICATION AND DO NOT AUTHORIZE CIGNA LEAVE SOLUTIONS, WHETHER USING THIS AUTHORIZATION OR ANOTHER VALID AUTHORIZATION, TO CONTACT YOUR HEALTH CARE PROVIDER, YOUR LEAVE MAY BE DENIED.**

I, _____ , _____ , employed at _____
hereby authorize the use or disclosure of my health information as described in this authorization.

I authorize representatives of Life Insurance Company of North America, which does business as Cigna Leave Solutions, to contact the health care provider who filled out this form to obtain medical information required for completion of this form and/or to clarity or validate medical information that was provided on this form. I understand such medical information will be obtained as permitted under the Family and Medical Leave Act (FMLA) and be limited only to what is required to assess my eligibility for leave under the FMLA. I also understand such information may be used to determine my eligibility for approval of leave, or for consideration of other leaves associated with my leave request, including applicable state family and medical leave laws and/or other leaves of absence administered by Cigna Leave Solutions. I understand that, although limited to the reason for which I am requesting leave, information about my health may related to any disorder of the immune system including, but not limited to HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment, but does not include psychotherapy notes.

If my employer, union, group association sponsors any other plans, whether or not underwritten or administered by Life Insurance Company of North America, or its affiliates, the information and/or records obtained may also be shared with the underwriting company [insurer] or administrators of those other plans, including their internal or external health management, disease management, wellness, employee/member assistance program or other similar programs, for the purpose of administering any service, benefit or feature described in those plans.

I agree to the terms of this authorization and understand that the use and further disclosure of information disclosed hereunder may no longer be subject to protection under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, though it may still be protected under other applicable privacy laws.

For any leave request, this authorization is valid for the shorter of 6 months or the duration of my leave. I am entitled to a copy of this authorization and a photographic or electronic copy of it is as valid as the original.

I understand that I have the right to revoke this authorization at any time by notifying Cigna Leave Solutions in writing.

I understand that the revocation is only effective after it is received and documented in Cigna Leave Solutions' leave management system. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. I understand that after this information is disclosed, federal law might not protect it and the recipient might re-disclose it.

_____ _____

**Signature of Employee** **Date Signed**

_____

**Print Name**

If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign this form on the basis of: _____