



**PHYSICIAN FORM FOR HANDICAPPED/DISABLED DEPENDENT**

**MR Type - for internal use only**

DATE	SUBSCRIBER'S NAME (EMPLOYEE)	DEPENDENT'S NAME		
SUBSCRIBER'S ADDRESS STREET:		CITY:	STATE:	ZIP CODE:
NAME OF HEALTH PLAN:		HEALTHPLAN CODE:	ID NUMBER	
GROUP NAME				GROUP/DIVISION NUMBER

***This form should be completed and signed by the primary treating physician for the dependent named above.***

***Please mail the completed form to: CIGNA HealthCare  
P.O. Box 692012  
San Antonio, TX 78269***

***Treating Physician Information:***

Physician Name:

Specialty:

License Number:

Address:

Telephone Number:

Fax Number:

Diagnosis(es) (ICD-9) \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

**A. Student Medical Leave of Absence:**

Please complete this section of the form if the patient is requesting a Student Medical Leave of Absence.

Does this patient qualify for a medically necessary Student Medical Leave of Absence?

Yes\_\_\_\_ No\_\_\_\_

If yes, please provide a short explanation below:

**Please Continue on Reverse Side**

**B. Handicapped/Disabled Dependent :**

Please complete this section of the form if the patient is requesting certification of handicapped/disabled status. Please answer the following questions and describe, in as complete a manner as possible, the extent of your patient's behavioral, cognitive and/or physical impairment which prevents gainful employment. This information will assist CIGNA HealthCare in determining this patient's eligibility for continued medical and/or dental coverage as a handicapped/disabled dependent.

1. What is the patient's diagnosis? \_\_\_\_\_
2. When was the patient's condition initially diagnosed? \_\_\_\_\_
3. How long have you treated the patient for the specific conditions which impact his/her ability to be gainfully employed? Number of years \_\_\_\_\_ Frequency of visits \_\_\_\_\_

***Please complete questions 4-11 if your patient is requesting certification of handicapped/disabled status due to Behavioral Health, Cognitive and/or Neurological Impairment (otherwise, skip to question 12) :***

4. How many hospital admissions have occurred for this diagnosis/condition in the past 12 months?  
\_\_\_\_\_
5. How many hospital admissions have occurred for this diagnosis/condition **prior to** the past 12 months? \_\_\_\_\_
6. Has the patient had an IQ test? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, what was the result? \_\_\_\_\_
7. Describe any cognitive or psychological impairment and the impact created on personal life skills and social interaction:

8. Please provide objective abnormal physical examination findings (e.g. , neurological deficit, contractures, loss of joint motion , etc):

9. Please identify any functional limitations that impair self-sustaining employment:

10. Is the condition static/permanent? Yes\_\_\_\_ No\_\_\_\_  
If no, when do you anticipate your patient's condition to improve?  
3 months\_\_\_\_\_ 6 months\_\_\_\_\_ 1 year\_\_\_\_\_ more than 1 year\_\_\_\_\_

11. Is this patient able to participate in a training or other educational program to achieve the skills necessary to reach self-sustaining employment? Yes\_\_\_\_ No\_\_\_\_  
If yes, when do you anticipate that your patient will be capable of self-sustaining employment?  
3 months\_\_\_\_\_ 6 months\_\_\_\_\_ 1 year\_\_\_\_\_ more than 1 year\_\_\_\_\_

***Please complete questions 12-17 if your patient is requesting certification of handicapped/  
disabled status due to Other Medical Impairment (e.g., Cardiac, Gastrointestinal,  
Musculoskeletal, Respiratory, Visual,etc.)***

12. How many hospital admissions have occurred for this diagnosis/condition in the past 12 months? \_\_\_\_\_

13. How many hospital admissions have occurred for this diagnosis/condition **prior to** the past 12 months? \_\_\_\_\_

14. Please provide objective physical examination findings:

15. Please provide any pertinent recent diagnostic test results:

16. Please identify any functional limitations that impair self-sustaining employment:

17. Is the condition static/permanent? Yes\_\_\_\_ No\_\_\_\_  
If no, when do you anticipate that your patient will be capable of self-sustaining employment?  
3 months\_\_\_\_\_ 6 months\_\_\_\_\_ 1 year\_\_\_\_\_ more than 1 year\_\_\_\_\_

Physician's Signature: \_\_\_\_\_

Physician's Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_