Reset

Standard Insurance Company
Benefits Department
PO Box 2800 Portland OR 97208 800.628.8600 Tel

MOSERS
WE ARE HERE FOR YOUR BENEFIT.

MOSERS Stay At Work Medical Information Request

Dear Employee: Please complete this section.

Employee Name _____ Birth Date _____

Employer **MOSERS** Policy Nr. **604201**

Dear Attending Physician: The purpose of this request is to help us determine whether we will be able to assist the patient to 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 patient's current symptoms, physical limitations and work activity restrictions _____

_____

_____

3. Planned course of treatment (include expected duration) _____

_____

_____

4. Do you have recommendations for workstation modifications/accommodations that will assist the patient to perform his/her job? ☐ Yes ☐ No

If yes, please list them_____

_____

How will the modifications/accommodations help the patient perform the functions of his/her job? _____

_____

_____

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