

Section 2 - Member's Authorization and Acknowledgment

HIPAA DISCLOSURE:

I authorize any licensed physician, medical provider, medical facility, or provider of health care or similar entity to release any and all of the following information to OPERS or its third party administrators:

Medical information with respect to any physical or mental condition and/or treatment of me, including confidential information regarding AIDS/HIV infection, communicable diseases, alcohol and substance abuse, and mental health.

I understand the information obtained will be included as part of the proof of claim and will be used to determine eligibility for claim benefits, return to employment opportunities, and assessment of ongoing treatment. Any information obtained will not be released to any person or organization except OPERS and its third party administrators.

I agree that a photographic copy of this Authorization shall be as valid as the original.

I understand that I may request a copy of this Authorization. This Authorization shall become effective on the date appearing next to my signature below.

I understand I have the right to revoke this Authorization at any time by notifying OPERS.

I understand that revoking this Authorization may impair necessary processing of my application.

Member Signature _____

Do not print or type name

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

Sections 3, 4, 5 and 6 of this form must be completed by the member's attending physician. The physician must be a licensed and practicing MD or DO.

Section 4 - Patient Information

Time Treating Member From:

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

 To:

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

Frequency of Office Visits for Disabling Condition(s) Monthly Qtr Semi-Ann Ann Other _____

Date of Last Office Visit for the Disabling Condition(s)

Month	Day	Year
<input type="text"/>	<input type="text"/>	<input type="text"/>

Do you have knowledge that the claimant/patient is receiving Workers' Compensation benefits for this disabling condition(s)?

Yes No or, I do not know

Are you the doctor of record for the Bureau of Workers' Compensation claim? Yes No N/A

Section 5 - Physician Findings - Please include any test results that enabled you to make your diagnosis (es).

DISABLING CONDITION(S):

A member is considered eligible for a disability benefit if the disabling condition prevents the performance of duties for their last employment and the disabling condition is expected to last at least 12 months.

1) Member Complaints:

2) Member Symptoms:

3) Disabling Condition(s):

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Sections 3, 4, 5 and 6 of this form must be completed by the member's attending physician. The physician must be a licensed and practicing MD or DO.

Section 5 - Physician Findings *(continued)* - Please include any test results that enabled you to make your diagnosis *(es)*.

4) Laboratory and/or Diagnostic Findings:

5) Historical Treatment/Care Plan:

6) Current Treatment/Care Plan:

7) Current Medications:

8) Has member shown medical improvement with Current Treatment/Care Plan? Yes No

If yes, indicate level of improvement: Fair Moderate Good Excellent

9) Prognosis for recovery from disabling condition(s): _____

Sections 3, 4, 5 and 6 of this form must be completed by the member's attending physician. The physician must be a licensed and practicing MD or DO.

Section 6 - Physician's Determination *(continued)* - Please include any test results that enabled you to make your diagnosis (es).

Disabling Condition(s) medical documentation must be included with this completed form.

Is/Are Disabling Condition(s) medical documentation attached? Yes No

If no, please explain:

Print Member's Name: _____ IS or IS NOT
considered permanently disabled due to the condition(s) described above.

Physician's Signature _____
Do not print or type name

Today's Date
Month Day Year

Physician's Medical Title _____ MD DO

Important: Please note Managed Medical Review Organization (MMro) may be contacting you regarding this application for disability benefits.

