New York Life Group Benefit Solutions
Medical Request Form

Fax Number: 866.472.3221

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

We are evaluating your patient's disability claim. Please respond to the following questions.
Please provide copies of supporting reports, such as office notes/consultations/testing.
(Failure to provide the reports may result in delay in the claim determination).

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by the GINA Title II from requesting or requiring genetic information of employees or their family members. 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. "Genetic Information," as defined by GINA, includes an individual's family 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.

Claimant Name:	Date of Birth:

What diagnoses are you treating your patient for? Please also include ICD code(s).

Date of Injury/Illness:	Is this condition work related? ☐ Yes ☐ No

What are the specific additional factors impacting return to work, if any?

When did you first treat your patient for this current impairment episode?	Have you treated your patient for this impairment prior to this episode? ☐ Yes ☐ No If Yes, when? _____	Date of last visit:	When is your patient's next office visit?

Does treatment plan for this impairment episode include any of the following? *(Please list as appropriate and provide supporting documentation)*

- ☐ Physical Therapy: _____
- ☐ Electrodiagnostic Studies: _____
- ☐ Surgery: _____
- ☐ Imaging Studies: _____
- ☐ Specialty Referral: _____
- ☐ Other: _____

Please list all current medications that are related to this impairment or impact return to work: *(Please include dosage and frequency)*

What are the specific restrictions that you have placed on your patient?
At Work:

_____

At Home *(Activities of Daily Living)*:

_____

Could your patient return to work at this time if accommodations were made for the listed restrictions? ☐ Yes ☐ 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 *(Please Print)*:	Degree & Specialty:

Address: *(Street, City, State, Zip Code)*

Telephone Number:	Fax Number:	Federal Tax ID #:

Physician Signature:	Date: