



New York Life Insurance Company
 Individual Disability Insurance
 1500 Main Street, Suite 1400, P.O. Box 15189
 Springfield, MA 01115-5189

Physician's Statement for Mental Health Conditions – Individual Disability Insurance

STEP 1 Patient information *To be completed by New York Life*

Name		Date of birth	
FIRST	MIDDLE	LAST	MM/DD/YYYY
Policy number(s)		Claim number(s)	

STEP 2 Attending Physician's Statement *To be completed by Attending Physician*

Section 1. Current Mental Status

Please provide DSM V Formulation and data that supports current diagnoses:

Initial observations associated with this episode of illness. Please provide the significant symptoms and critical mental status findings.

Current Mental Status: ☐ Resolved ☐ Improved ☐ Unchanged ☐ Regressed

Date of last mental status exam:	Thought process:
General appearance:	Psychotic symptoms:
Speech:	Judgement:
Psychomotor slowing or agitation:	Insight:
Mood – Reported:	Appetite:
Mood – Observed:	Sleep:
Anxiety level:	Cognitive function:

Functional Capacities (Please focus on how the diagnosis is impacting ability to function.)

How does the patient's **current** condition impact their ability to function in the following areas?

Work:
Home:
Social:

Please comment on your patient's motivation to engage in focused treatment which could allow for increased functionality and return to work:

STEP 2 Attending Physician's Statement *Continued from previous page***Section 2. Treatment**Date of last
appointment: MM/DD/YYYYDate of next
appointment: MM/DD/YYYY**Current psychotropic medications:**
Medication

Dose

Frequency Taken

Frequency of psychotropic medication review:

Current frequency of individual psychotherapy/counseling:

What are the treatment goals?

Is treatment compliance an issue?

☐

Yes

☐

No

If yes, please provide details:

Is drug or alcohol use a factor in the patient's current condition?

☐

Yes

☐

No

If yes, please provide details:

Is the patient in a recovery program?

☐

Yes

☐

No

If yes, please provide details:

Section 3. Occupational Status

How is return to work being addressed as part of the treatment plan?

What is the anticipated return to work date? MM/DD/YYYY

If the patient came to their next appointment with an appropriate full time return to work opportunity, would you support it? ☐ Yes ☐ No
If not, please provide details:Are there any legal or administrative issues impacting a return to work? ☐ Yes ☐ No
If yes, please provide details:Is the patient competent
to handle their funds? ☐ Yes ☐ No**STEP 3 Attending Physician's Declaration and Signature**Attending Physician
Name

Specialty/ Degree

FIRST

MIDDLE

LAST

Address

Phone number

STREET

CITY

STATE

ZIP

Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. Please refer to the enclosed page entitled STATE VARIATIONS OF FRAUD WARNINGS enclosure for specific notices required in certain jurisdictions.

I declare that the answers on this statement are true to the best of my knowledge and belief. I understand that periodic updates (including providing a copy of medical records when requested) will be required in the event of continuing claim.

X

Date

Physician's Signature

STEP 4 Done! Send us your completed form.Mail: **New York Life, Individual Disability Insurance, 1500 Main Street, Suite 1400, P.O. Box 15189, Springfield, MA 01115-5189**Fax: **1-(833) 963-3462**Email: **IDIClaims@IDI.newyorklife.com**

Questions? Call us at (844)-420-1391