Medical Documentation Template for Disability Insurance Reinstatement

Patient Information

Full Name:

_____

Date of Birth:

_____

Insurance Policy #:

_____

Contact Number:

_____

Address:

_____

Practitioner Information

Physician/Provider Name:

_____

Medical License #:

_____

Practice/Facility Name:

_____

Provider Contact Information:

_____

Medical Status & Relevant History

Primary Diagnosis:

_____

Secondary Diagnoses (if any):

_____

Onset Date of Disability:

_____

Summary of medical history, clinical findings, and rationale for disability:

Relevant laboratory, imaging, or diagnostic results:

Current Functional Status

Description of Current Functional Limitations (physical, cognitive, psychological):

Current medications/treatments:

Response to treatment and prognosis:

Physician Statement

Please state your clinical opinion regarding the patient's current ability to return to work or function, and whether continuation or reinstatement of disability benefits is medically necessary.

Certification

Physician/Provider Signature:

_____

Date:

_____

Print Name:

_____