Department of Employee Trust Funds

INCOME CONTINUATION INSURANCE (ICI) MEDICAL REPORT

Wis. Stat. § 40.61 and 40.62

NOTE TO CLAIMANT: Personally identifiable information, such as your Social Security number, date of birth, etc., will not be used for any purpose other than for the administration of the benefit programs administered by the Department of Employee Trust Funds (ETF) and its claims administrator. Complete Section I. below and the top of the back page. Then immediately take this form to your physician for completion.

I. AUTHORIZATION TO RELEASE MEDICAL INFORMATION (TYPE OR PRINT IN BLACK INK)

Claimant's Name (First, Middle, Last)	SS#	Birthdate (MM/DD/CCYY)	Occupation
		| |	

Address: Street	City	State	Zip Code	Telephone Number
				( )

Last Day Worked	Employer/Agency Name	Division/Location
| |		

Physician's Name (First, Last)

I hereby authorize this physician who has attended me or examined me to furnish to ETF and its claims administrator Aetna, any and all information with respect to any illness or injury, medical history, medical records, consultation, prescriptions and all treatment. I understand the specific type of information to be released may include records pertaining to alcohol abuse, drug abuse, records with reference to child abuse, developmental disabilities, mental illness, HTLV-III (AIDS) testing and results, and/or treatment records. This release is being made for the purpose of determining eligibility for disability benefits. A copy of this authorization shall be considered as effective and valid as the original and shall be valid for the duration of the claim, but not to exceed one year from the date signed.

ICI Claimant's Signature	Date (MM/DD/CCYY)
	/ /

INSTRUCTIONS TO PHYSICIAN–This form must be completed by a physician. "PHYSICIAN" means a medical doctor, doctor of osteopath or surgeon licensed to practice by a state within the United States of America. A licensed PHYSICIAN does not include the CLAIMANT. A PHYSICIAN also includes such other licensed medical professional (for example, a podiatrist, dentist, nurse practitioner, physician's assistant, psychologist) who is acting within the lawful scope of his/her license and performs a service which is supervised by a licensed medical doctor, doctor of osteopath or surgeon (not required for D.P.M. or D.D.S.). This individual is applying for a disability benefit from the State of Wisconsin Department of Employee Trust Funds (ETF). To avoid the delay associated with incomplete medical reports, please answer each question in Section II on the back of this form. After you have answered all questions, be sure to personally sign the report. **Any cost incurred for this report is the applicant's responsibility.**

Please mail the completed and signed form directly to ETF. **Do not return the form to the patient.** Timely submission of this form is very important.

Mail to: ETF, PO BOX 7931, MADISON WI 53707-7931

Claimant's Name:	SS Number

II. PHYSICIAN'S REPORT OF PATIENT'S DISABILITY

1. **Please describe, in your opinion, the patient's impairment (diagnosis) and describe complications, if any. Please attach copies of all medical histories, reports or notes related to your opinion. ICD.9** _____

2. **Objective Findings:**

3. **Disability is the result of :** ☐ Illness ☐ Injury ☐ Pregnancy (Due Date Delivery Date)

4. **Is the disability indicated in Box #1 due to a work-related illness or injury?** ☐ Yes ☐ No

5. **Office Visits/Examinations/Lab/X-ray/Therapy since the last day worked:**

Date(s)	Type of Service	Results/Findings

6.

Hospital Name	Address	
In-patient Admission Date	Discharge Date	Reason for Admission
E.R. Admission Date	Type of Treatment/Reason for Admission	

7. **Surgical Procedure(s)** | **Date(s)**

8. **Totally disabled means, for purposes of Short Term Income Continuation Insurance:**
During the first 12 months of disability the employee's inability by reason of any medically determinable physical or mental impairment as supported by objective medical evidence (e.g. blood tests, MRI, CAT scan, X-rays, etc.) to perform all of the essential duties of his or her occupation.

In your opinion, is the patient's current medical condition totally disabling as defined above?

☐ Yes ☐ No If yes, from ___/___/___ through ___/___/___ (MM/DD/CCYY)

When do you believe the patient will be able to return to work? ___/___/___

Reasons/Comments:_____

9. **In your opinion, is the patient's current condition totally and permanently disabling from any occupation?**

☐ Yes ☐ No

Reasons/Comments: _____

CERTIFICATION

This is to certify that I, a licensed and practicing physician of the United States of America, have examined the patient in my professional capacity and find the nature and extent of the disability of such person to be as stated. **(NOTE: Physicians not licensed in Wisconsin must provide verification of their state licensing.)**

Physician's Typed or Printed Name (as it appears on your medical license)	Specialty	License Number
Physician's Address		Telephone Number
Physician's Signature (not to be signed by an authorized representative or alternate health care provider)		Date (MM/DD/CCYY)