Renaissance
DENTAL • VISION • LIFE • DISABILITY

Renaissance Life & Health
Insurance Company of America

PFML MEDICAL CERTIFICATION FORM

-Please Print or Type in Dark Ink-

INSTRUCTIONS

INSTRUCTIONS TO EMPLOYEE WHO IS REQUESTING LEAVE

1. Complete the Employee and Patient Information section.
2. Give this form to the treating medical provider.
3. After the provider completes this form, attach it with your PFML Claim Form and submit all documentation together to the carrier.

INSTRUCTIONS TO MEDICAL PROVIDER

Complete this form and return it to the employee/patient. The employee must return this form along with their completed claim form to the carrier.

SECTION I | EMPLOYEE AND PATIENT INFORMATION (TO BE COMPLETED BY THE EMPLOYEE)

EMPLOYEE INFORMATION

Employee First Name:	Employee Last Name:

PATIENT INFORMATION

Patient Name:	☐ Same as Employee
Patient Date of Birth (mm/dd/yyyy):	

SECTION II | MEDICAL CERTIFICATION (TO BE COMPLETED BY THE MEDICAL PROVIDER)

INFORMATION ABOUT THE HEALTH CONDITION

Briefly describe the medical facts related to the condition(s):

Date patient was first diagnosed with the condition(s):_____

Estimated duration of the condition:

☐ Temporary, estimated to resolve within _____ ☐ Days ☐ Months

☐ Permanent/Lifelong

Please indicate if any of the following apply:

☐ **Inpatient** care overnight or longer Dates:_____

☐ **Incapacity for more than 3 consecutive days plus follow up treatment**

Start Date of Incapacity: _____ Estimated End Date of Incapacity: _____

Date of First Treatment on/after Start Date of Incapacity: _____

Follow up appointment date(s): _____

Is prescription medication required? ☐ Yes ☐ No

☐ **Pregnancy** Expected Delivery Date _____

Are there any pre-term complications? ☐ Yes ☐ No If the leave start date is more than 4 weeks before the estimated delivery date, please describe the medical circumstances requiring the additional time off: _____

_____

☐ **Chronic Condition requiring treatment two or more times per year**

Most recent two appointment dates _____ and _____

Next scheduled appointment date: _____

☐ **Permanent/Long-Term Condition requiring continuing medical supervision**

☐ **Condition requiring multiple treatments to prevent a period of incapacity or for restorative surgery due to an accident or injury**

Describe required treatment: _____

_____

☐ **Organ or Bone Marrow Donor**

EMPLOYEE'S OWN MEDICAL CONDITION SECTION (COMPLETE THIS SECTION ONLY IF PATIENT IS THE EMPLOYEE. IF THE PATIENT IS NOT THE EMPLOYEE, SKIP THIS SECTION).

Is the health condition due to a work-related injury? ☐ Yes ☐ No	**Does the medical condition prevent the employee from working?** ☐ Yes ☐ No

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FAMILY CARE SECTION (COMPLETE THIS SECTION ONLY IF PATIENT IS NOT THE EMPLOYEE. IF THE PATIENT IS THE EMPLOYEE, SKIP THIS SECTION. NOTE: IF THE EMPLOYEE IS NOT YOUR PATIENT, YOU MAY NEED AUTHORIZATION FROM YOUR PATIENT TO SHARE MEDICAL INFORMATION WITH THE EMPLOYEE AND PFML CARRIER. PLEASE OBTAIN ANY NECESSARY PATIENT AUTHORIZATION FOR YOUR RECORDS).

Is the health condition related to the patient's active military service? ☐ Yes ☐ No

Does or will the patient require care from a family member? ☐ Yes ☐ No

If yes, type of care required:

☐ Assistance with daily activities or medical needs
☐ Psychological comfort
☐ Transportation
☐ Other _____

ABSENCES RELATED TO THE HEALTH CONDITION: PLEASE INDICATE THE TYPE AND DURATION OF ABSENCES REQUIRED (EITHER FOR THE EMPLOYEE'S OWN MEDICAL CONDITION OR TO PROVIDE CARE IF THE PATIENT IS A FAMILY MEMBER).

Continuous (full day absences for a consecutive period of days)

First Day of Leave: _____Date is (check one) ☐ Actual ☐ Estimated
Last Day of Leave: _____Date is (check one) ☐ Actual ☐ Estimated
Return to Work Date: _____Date is (check one) ☐ Actual ☐ Estimated/Re-evaluation Date
☐ **Not Applicable: Continuous leave is not needed**

Reduced Schedule (partial day absences for a consecutive period of days – for example, 2 hours absent every day for a 2-week period)

Number of Hours Absent per Day_____
First Day of Reduced Schedule: _____Date is (check one) ☐ Actual ☐ Estimated
Last Day of Reduced Schedule: _____Date is (check one) ☐ Actual ☐ Estimated
Return to Full Time Work Date: _____Date is (check one) ☐ Actual ☐ Estimated/Re-evaluation Date
☐ **Not Applicable: Reduced schedule leave is not needed**

Intermittent or Periodic (absences that occur at varying times and varying numbers of hours per absence)

Reasons(s) for periodic absences (check all that apply)
☐ planned medical appointments/treatment ☐ episodic flare-ups of the condition
Expected Timeframe During Which Periodic Absences Are Needed:
Start Date: _____ End Date: _____
Estimated Frequency of Absences: _____Times ☐ Per Week ☐ Per Month
Estimated Duration of Each Absence: (check all that apply)
☐ Full Day Absences
☐ Partial Day Absences of approximately _____ hours per absence
☐ **Not Applicable: Intermittent leave is not needed**

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PROVIDER INFORMATION AND DECLARATION/SIGNATURE

BY SIGNING BELOW I CERTIFY THAT THE ABOVE STATEMENTS ARE TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF, THAT I HAVE EXAMINED THE PATIENT AND ANSWERED THE QUESTIONS ACCURATELY AND TO THE BEST OF MY ABILITY, AND THAT I AM A HEALTHCARE PROVIDER AUTHORIZED TO CERTIFY THEIR CONDITION.

Provider Name _____

Specialty/Area of Practice _____ License # _____

Practice Name_____

Address _____

Office Phone_____ Office Fax _____

*X*_____ _____

Provider Signature **Date Signed** (mm/dd/yyyy)

NOTE: IF THIS FORM IS NOT COMPLETED IN FULL, DETERMINATION OF BENEFITS WILL BE DELAYED UNTIL ALL REQUIRED INFORMATION HAS BEEN RECEIVED. WRITE "NA" IN NON-APPLICABLE SECTIONS.

—State Fraud Warnings on Following Pages—

LIFE AND DISABILITY STATE FRAUD WARNING STATEMENTS:

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE STATEMENT IN AN APPLICATION FOR INSURANCE MAY BE GUILTY OF A CRIMINAL OFFENSE AND SUBJECT TO PENALTIES UNDER STATE LAW. PLEASE SEE BELOW FOR STATE-SPECIFIC VARIATIONS OF THIS FRAUD NOTICE.

CALIFORNIA: WARNING: FOR YOUR PROTECTION CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM: ANY PERSON WHO KNOWINGLY PRESENTS FALSE OR FRAUDULENT INFORMATION TO OBTAIN OR AMEND INSURANCE COVERAGE OR TO MAKE A CLAIM FOR THE PAYMENT OF A LOSS IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN STATE PRISON.

FLORIDA: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

NEW YORK (EXCLUDING LIFE INSURANCE): 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.

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