



Capacity Questionnaire

1 First Name MI Last Name Claim Number

2 To Be Completed by Physician In your medical opinion does the patient have: Full-time work capacity (8 hours, 5 days per week)? Part-time transitional work capacity?

When do you estimate the patient will be capable of full-time return to work?

Please indicate below what your patient is capable of performing currently during a typical day:

Table with 5 columns: % of time, Never (0%), Occasionally (1%-33%), Frequently (34%-66%), Constantly (67%-100%). Rows include activities like Standing, Walking, Sitting, Climbing Stairs, etc.





Capacity Questionnaire, continued

Form fields for First Name, MI, Last Name, and Claim Number.

Please list any other medically necessary restrictions (activities he/she should not do) and/or limitations(activities he/she cannot do):

Horizontal lines for listing restrictions and limitations.

Please explain and comment on the expected duration of any restrictions and/or limitations.

Horizontal lines for explaining duration of restrictions.

If your patient has restrictions or limitations that impact work hours or work duties, are there any accommodative measures (i.e., modifications to the workplace or job, to work equipment, or to how work is done) that you believe would allow the patient to increase work capacity? Examples of accommodations include: adaptive devices (e.g., voice recognition software, foot-controlled mouse, lifting devices); working from home; scheduling flexibility; breaks during the workday; etc.

Horizontal lines for providing accommodative measures.

3 Physician Certification

My opinion is based on: [ ] The patient's self-reported severity of symptoms. [ ] Objective findings.

The above restrictions and limitations are an estimate of my patient's current capacity and a vocational rehabilitation program would be beneficial in order for this patient to return to work. [ ] Yes [ ] No

We would appreciate a response within two weeks from when you receive this letter. In the absence of return communication, our opinion will be based on the information we have available in the file.

Fraud Notice:

Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is/may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

I have read and understand the terms and requirements of the fraud warning and I certify the above statements are true.

Date Signed form field.

Physician's Signature: \_\_\_\_\_

Physician's Printed Name: \_\_\_\_\_

Specialty form field.

Please FAX this completed document to 1-877-889-4885. Please make sure the claimant's name and claim number are entered at the top of each page. Thank You.

