



Behavioral Health Capacity Questionnaire

1 First Name MI Last Name Claim Number

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FUNCTIONAL CAPACITY (OVER LAST 14 DAYS):	
Please describe any restrictions (work duties your patient should not do) because of psychiatric symptoms/disease.	
Please describe any limitations (work duties your patient cannot do) because of psychiatric symptoms/disease.	
Please describe any psychosocial stressors that caused your patient to leave work.	
Please describe any work events that caused your patient to leave work.	
Is alcohol or drug use a contributing factor to condition? Explain.	
Please describe any significant personality disorder/traits.	
If your patient has cognitive complaints, are they primary or secondary to a psychiatric condition? Explain.	
If there is cognitive disease, please describe how it was measured.	
What treatment modalities will be used to help restore your patient to baseline functioning?	
Do you believe return to work plays an important role in recovery from mental illness and is that a goal of treatment?	Yes No
What, if any, are the barriers to returning to work at this time?	
Do you believe your patient has either part-time or full-time capacity to return to work at this time? If not, why?	Full-time work capacity: <input type="checkbox"/> Yes <input type="checkbox"/> No Part-time work capacity: <input type="checkbox"/> Yes _____ hours/day <input type="checkbox"/> No
When do you predict your patient will be able to return to work on a full-time basis?	
If your patient can't return to work at their current position, could they perform their same duties in an alternative setting at this time?	Yes No





Group Disability Insurance
The Prudential Insurance Company of America
Disability Management Services
PO Box 13480, Philadelphia, PA 19176
Tel: 800-842-1718 Fax: 877-889-4885
www.prudential.com/forphysicians

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First Name	MI	Last Name	Claim Number
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

3 Treating Provider Certification

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.

Treating Provider's Signature: _____ Date

Treating Provider's Printed Name: _____

Specialty

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

