Standard Insurance Company

Benefits Department
P.O. Box 2800 Portland, OR 97208 855.WPP.PROG (855.977.7764)

Reset

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Workplace Possibilities Medical Information Request

Patient name _____ Date of birth _____

Dear attending physician: The purpose of this request is to help us determine whether we will be able to assist the patient listed above to remain at work or to return to work as soon as medically appropriate.
Please include results of diagnostic testing and pertinent chart notes.

1. Diagnosis (include the ICD code)_____

_____

Date of most recent visit_____ Frequency of visits _____

Expected duration of impairment from this condition _____

2. Describe patient's current symptoms, physical limitations and work activity restrictions _____

_____

_____

3. Planned course of treatment (include expected duration) _____

_____

_____

4. Do you have recommendations for workstation modifications/accommodations that will assist the patient to perform his/her job? ☐ Yes ☐ No

If yes, please list them _____

_____

How will the modifications/accommodations help the patient perform the functions of his/her job? _____

_____

_____

Some states require us to inform you that any person who knowingly and with intent to injure, defraud or deceive an insurance company, or other person, files a statement containing false, or misleading information concerning any fact material hereto commits a fraudulent insurance act which is subject to civil and/or criminal penalties, depending upon the state. Such actions may be deemed a felony and substantial fines may be imposed.

Physician's signature		Date	
Physician's name (please print)		Specialty	
Address	City	State	ZIP
Phone	Fax		

Please fax completed form to 971.321.5727 or 855.207.6115.

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