Form MSD12
R032023

PRINT ALL INFORMATION
www.lasersonline.org

P.O. Box 44213, Baton Rouge, LA 70804-4213
225.922.0600 · Toll-Free 1.800.256.3000
Fax 225.935.2856

Attending Physician's Statement

Member's First Name	Middle Name	Last Name	Today's Date	Social Security Number

IMPORTANT: Complete the entire form. Follow the specific instructions for each section. All dates should be in MM/DD/YYYY format.

SECTION 1: MEMBER'S INFORMATION

Member's Mailing Address	City	State	Zip Code

Daytime Area Code/Phone Number	Evening Area Code/Phone Number	Email Address	Member's Birth Date

SECTION 2: INSTRUCTIONS FOR THE ATTENDING PHYSICIAN

TO THE ATTENDING PHYSICIAN -- Please type or print all information and complete this form in its entirety. **Failure to do so will result in a delay of benefits to your patient.** Return the completed form to LASERS at the above mailing address. The purpose of this report is to assist us in making a determination for continuance of disability benefits. In completing this report, please include sufficient detail of history, physical and diagnostic finding, clinical course, and therapy to enable us to make this determination. **LASERS does not use the same disability standards as Social Security. The LASERS standard for disability retirement requires that members only be disabled from their position with the State of Louisiana.**

SECTION 3: PATIENT INFORMATION & DIAGNOSIS

☐ Male
☐ Female

Height	Weight

Diagnosis (including any complications):

Subjective symptoms:

Objective findings:

CONTINUE ON NEXT PAGE

Social Security Number

SECTION 4: TREATMENT

Date of first visit for illness/injury

Date of last visit

Nature and dates of treatment:

Frequency of visits:

☐ Weekly ☐ Monthly

☐ Other_______________

SECTION 5: PROGRESS

Check one:

☐ Recovered
☐ Improved
☐ Unchanged
☐ Retrogressed

Present Status:

☐ Ambulatory
☐ House Confined
☐ Bed Confined
☐ Hospitalized

Indicate how activities are restricted:

If hospitalized, name of hospital and dates of confinement:

SECTION 6: EFFECT OF PHYSICAL OR MENTAL IMPAIRMENT

Explain, in sufficient detail, the extent that the patient's illness or injury qualifies the patient to remain disabled:

What are the patient's current functional abilities in the following areas in hours (based on an 8-hour day)

Sitting ____________ ☐ Continuously ☐ With Rests

Standing ____________ ☐ Continuously ☐ With Rests

Walking ____________ ☐ Continuously ☐ With Rests

Lifting ☐ 1-10 lbs. ☐ 10-25 lbs. ☐ 25-50 lbs. ☐ Over 50 lbs.

Cardiac Functional Capacity (if applicable). Rate based on American Heart Association Rules:

☐ Class 1 (no limitation) ☐ Class 3 (marked limitation)
☐ Class 2 (slight limitation) ☐ Class 4 (complete limitation)

Activities:	Never	Occasionally	Frequently	No Restriction
Bending	☐	☐	☐	☐
Stooping	☐	☐	☐	☐
Climbing	☐	☐	☐	☐
Squatting	☐	☐	☐	☐
Reach above shoulder	☐	☐	☐	☐
Driving	☐	☐	☐	☐

Blood Pressure ________________

Are there any cognitive deficits that impair functional capacity? ☐ Yes ☐ No

If yes, please describe:

Do you expect the patient's condition to improve in the future? ☐ Yes ☐ No

If yes, please give approximate date

If no, has the patient achieved maximum medical improvements?

CONTINUE ON NEXT PAGE

Social Security Number

SECTION 7: REMARKS & RECOMMENDATIONS

Additional studies, consultations, or vocational training:

Improvement is not expected, or medically likely, and no further annual certification of disability is necessary. ☐ Agree ☐ Disagree

Signature of Attending Physician

Comments:

<u>YOU MUST SELECT ONE OF THE FOLLOWING TWO OPTIONS:</u>

☐ **In my opinion, this employee remains incapacitated and should remain retired (cannot return to position from which he/she retired).**

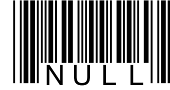
☐ **In my opinion, this employee needs to be re-evaluated by a LASERS Board Physician (can return to work in position from which he/she retired).**

Print Name of Attending Physician | **Specialty/Degree** | **Daytime Area Code/Phone Number**

Mailing Address | **City** | **State** | **Zip Code**

Signature of Attending Physician | **Date**

Form MEDBILLS
R032020



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Medical Bills

Patient's First Name	Middle Name	Last Name	Today's Date	Social Security Number

SECTION 1: INSTRUCTIONS

IMPORTANT: You must include a copy of the medical bill(s) issued to the patient in order to receive payment from LASERS.

Form must be completed in its entirety by the physician or physician's designee.

SECTION 2: INVOICE

Attending Physician's Name	Specialty / Degree	Daytime Area Code/Phone Number

Provide the itemized detail of the services that were required to complete the *Attending Physician Statement*. Services indicated below should pertain to the current office visit **only**. Once received in the LASERS office, a check will be issued as requested below.

Date	Professional Service	Charge ($)	Paid by Insurance ($)	Balance ($)
Total ($)				

Requested Check Amount	Payable to

Mailing Address	City	State	Zip Code

Signature of Physician or Designee	Title	Date