



## CM Regent Solutions Disability Claim Statement – Behavioral Health Treating Provider Statement

Claim is for:  Short-Term Disability  Long-Term Disability

### Instructions

The Treating Provider must please complete each section of this form, and then sign and date it and return it to us.

**You can submit this form and any additional documents by mail or fax.**

**If complete and accurate information is not provided, we may need to request additional information, which could delay disability benefits for your patient.**

Group policy number
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### 1 Patient information

The patient is responsible for any costs associated with the completion of this form.

Name of patient (first, middle initial, last)				<input type="checkbox"/> M
				<input type="checkbox"/> F
Street Address	City	State	Zip code	
Social Security number	Date of birth (mm/dd/yyyy)	Phone number		
Name of employer (Parent company name)				

Use current DSM:

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### 2 Treatment details

Please answer as completely as possible. This is important so we can process your patient's disability benefits quickly. If we need to follow up with you, your patient's benefits may be delayed.

Date of first signs of illness	Date of first exam	Date of recent exam
Frequency of visits: <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other (specify):		
Has the patient ever had a psychiatric hospitalization, partial hospitalization, intensive outpatient treatment? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No		

**2 Treatment details, continued**

Facility name			
Street Address	City	State	Zip code
Admission date (mm/dd/yyyy):		Discharge date (mm/dd/yyyy):	

Provide the names of any current medications.

Please indicate any recent changes in medication and the reason for the change.

What are the patient's treatment goals and estimated duration for treatment?

Describe the patient's initial reason for seeking treatment. Specify how and when the symptoms first appeared and the progression of symptoms to current level.

Describe the patient's current symptoms.

Have any quantitative evaluations of functional impairment been performed? .....  Yes  No  
If "Yes," please list the psychological / neuropsychological testing performed and provide copies of the test and the raw data.  
  
If "No," have any evaluations been planned? Specify scheduled dates, if any.

**Mental status findings:**

Is the patient appropriately groomed? .....  Yes  No  
Please explain:

Impairment in concentration, thought process, or memory? .....  Yes  No  
Please explain:

Is the patient capable of managing his/her financial affairs? .....  Yes  No

If yes, do you believe this patient is competent to endorse checks? .....  Yes  No

**2 Treatment details, continued**

Behavior:

- Normal       Agitated       Irritable       Belligerent  
 Other:

Speech:

- Appropriate       Tangential       Rapid / pressured       Delayed       Monotone  
 Other:

Mood:

- Appropriate       Depressed       Anxious       Hostile       Euphoric       Agitated  
 Other:

Are there activities your patient is **unable** to perform because of cognitive difficulties or psychiatric symptoms? .....  Yes    No

Please explain:

Are there activities the patient **should not** do because it would create greater harm to their psychiatric condition? .....  Yes    No

Please explain:

Do you feel that the patient's condition is precipitated by a situation at their place of employment? .....  Yes    No

If "Yes," please provide the details of the employment situation.

Are the patient's problems related to alcohol or drug abuse? .....  Yes    No

If "Yes," please specify, including onset, severity, types of drugs used and prior treatment.

Is return-to-work part of your treatment plan? .....  Yes    No

Please provide estimated return-to-work date (mm/dd/yyyy): \_\_\_\_\_  Part-time    Full-time

How will you determine when the patient is ready to return to work?

**2 Treatment details, continued**

Specify any other factors that may have precipitated and could influence recovery and return to work.  
(e.g. family history, effects of physical illness, psychological history, educational history, inability to tolerate medications, legal or licensing difficulties, financial difficulties, occupational issues, etc.)

Has this patient ever suffered from symptoms of the same, similar or other mental or emotional disorder in the past? .....  Yes  No  Don't know

**3 Certification and signature**

I certify that the above statements are true and complete. I have read or had read to me the fraud warning for my state

Name of Treating Provider (first, middle initial, last)			Tax ID #	
Street address		City	State	Zip code
Specialty	Phone Number		Fax Number	

Treating Provider signature (original signature required) X	Date signed (mm/dd/yyyy)
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## 4 Fraud warnings

**General fraud warning:** 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 subjects such person to criminal and civil penalties.

**AK:** A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

**AL:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

**AR, LA, MA, MN, TX and WV:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**AZ:** For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

**CA:** For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**CO:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**DC:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**DE, ID and IN:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

**FL:** 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.

**KS:** 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 may be guilty of insurance fraud as determined by a court of law.

**KY:** Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

**MD:** Any person who knowingly OR willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly OR willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**ME:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**NH:** Any person who, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

**NJ:** Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

**NM:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

**OH:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

## 6 Fraud warnings, continued

**OK:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**OR:** Any person who, with intent to defraud or knowingly providing false information may be guilty of fraud and may be subject to civil or criminal penalties.

**PR:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars (\$5,000) and not more than ten thousand dollars (\$10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

**RI:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**TN and WA:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**VA:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

**VT:** 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.

## Contact us



**By mail**

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**By fax**

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