MetLife

# Certification of health care provider for care of covered service member Family and Medical Leave Act (FMLA)

Metropolitan Life Insurance Company

### Things to know before you begin

- Please complete Sections 1 and 2 before giving this form to the medical provider.
- Health Care Provider to fill out Sections 3, 4 and 5, and sign. Documents without the treating Health Care Provider and employee's/patient's signatures will be considered incomplete.
- Remember to include Employee First name, Employee Last name and Claim number in the spaces provided on all pages of this form.

Reminder: Forms marked as lifetime, unknown, as needed, indeterminate or the like, may be returned as incomplete.

## SECTION 1: Employee/Caregiver Information

| Employee - First name | Middle name | Last name | Claim number |
|---|---|---|---|
| | | | |

Name of Employer *(this is the employer of the employee requesting leave to care for current service member or veteran)*

## SECTION 2: Patient/Family Member Information

| Patient - First name | Middle name | Last name |
|---|---|---|
| | | |

Date of birth *(mm/dd/yyyy)*

Gender

☐ Male ☐ Female

**Relationship to employee:**

Please check ONLY one:

☐ Spouse ☐ Adult child

☐ Parent ☐ Next of kin

☐ Other - Please provide relationship:

**Service member's affiliation:**

Please check ONLY one:

☐ Regular Armed Forces ☐ Reserves

☐ National Guard ☐ Veteran

☐ Other - Please provide current affiliation:

**Service member or Veteran's military service information:**

Branch:

☐ Air Force ☐ Army ☐ Marine Corps ☐ Navy

☐ Other - Please provide current branch information:

| Rank | Unit |
|---|---|
| | |

| First name | Middle initial | Last name | Claim number |
|---|---|---|---|
| | | | |

Is the service member on the Temporary Disability Retired List (TDRL?) ☐ Yes ☐ No

Is this person on the permanent disability retired list? ☐ Yes ☐ No

## SECTION 3: Health Care Provider Instructions

**To complete the application, this section must be filled out by the Health care provider prior to submission *(please note this is an internal Department of Defense [DOD] casualty assistance designation used by DOD healthcare providers.)***

Check medical condition classification:

☐ (VSI) Very Seriously Ill/Injured *(life is in imminent danger)*
☐ (SI) Seriously Injured *(cause for immediate concern)*
☐ Other *(deems service member unfit for duty)*

Was illness or injury incurred in the line of duty? ☐ Yes ☐ No

Was the patient admitted for an overnight stay in a hospital, hospice, or residential medical care facility? ☐ Yes ☐ No

If yes, please provide admission and discharge dates below.

| Date admitted *(mm/dd/yyyy)* | Date discharged *(mm/dd/yyyy)* |
|---|---|
| | |

Dates you treated the patient for this condition:

| First visit *(mm/dd/yyyy)* | Last visit *(mm/dd/yyyy)* | Next visit *(mm/dd/yyyy)* |
|---|---|---|
| | | |

Are there any other treating physicians or consultants involved in your patient's care? ☐ Yes ☐ No

**Please check all medical facts below which support the medical conditions marked above.**

☐ Extended periods of incapacitation - actively receiving treatments
☐ Extended periods of incapacitation - not receiving active regular treatments.
☐ Injury/Accident
☐ Therapy - on-going *(PT/Dialysis/Psychological/OT)*
☐ 2 or more treatments by a health care provider: If other than yourself, please list below.

☐ **Other(s):**

☐ **Prescription medication: Please list below.**

NOTE: Routine examinations or directions/medications which may be obtained without treatment from a health care provider *(ex. aspirin, bed rest)* are NOT considered a regimen of treatment.

| First name | Middle initial | Last name | Claim number |
|---|---|---|---|
| | | | |

**Please describe the care needed and the reason the family member must leave work to provide such care.**

## SECTION 4: Amount of Leave Needed

**Continuous absence details:** Will your patient need to be absent from work for a single continuous period of time due to their own serious health condition? If so, please select the checkbox below and provide accurate or estimated dates for this period of absence.

☐ Single continuous absence period

| Start date *(mm/dd/yyyy)* | End date *(mm/dd/yyyy)* |
|---|---|
| | |

**Intermittent absence details:** Will your patient need an intermittent absence and/or reduced work schedule due to their own serious health condition? If so, please check the box below and provide approximately how long your patient will need the intermittent absence outlined below.

☐ Intermittent absence/Reduced work schedule

| Start date *(mm/dd/yyyy)* | End date *(mm/dd/yyyy)* |
|---|---|
| | |

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have.

**Example:**

FREQUENCY of episode 02 times per: ☐ week, or ☒ month, or ☐ year

LENGTH of episode: ☐ minute(s) 01 hour(s) ☐ full day(s)

**FREQUENCY of episode** ☐ **times per:** ☐ week, or ☐ month, or ☐ year

**LENGTH of episode:** ☐ minute(s) ☐ hour(s) ☐ full day(s)

**In the space provided below, please provide any additional relevant information specific to the need for the patient to take time away from work.**

| First name | Middle initial | Last name | Claim number |
|---|---|---|---|
| | | | |

## SECTION 5: Health Care Provider Information

| Physician - First name | Middle name | Last name |
|---|---|---|
| | | |

Physician area of specialty *(i.e., General Practitioner, Oncologist, Obstetrician)*

| Office phone number | Office fax number |
|---|---|
| | |

Office email address

| Office address | Suite |
|---|---|
| | |

| City | State | ZIP code |
|---|---|---|
| | ▼ | |

### Please Read:

**GINA Disclaimer:** The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. *Genetic Information* as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.
**Fraud Notice:** Any person who knowingly and with intent to injure, defraud, or deceive any person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive or misleading facts or information is/may be guilty of a crime and may be prosecuted and punished. Penalties may include fines, civil damages and criminal penalties, including confinement in prison.
By signing below, I attest that I am the treating Health care provider to the listed patient. The clinical information I am providing is in regards to the dates of absences listed above. I certify that my patient's family member *(employee)* must be absent from work or have a modified work schedule due to this condition.

| Sign Here | Signature of Health care provider | Date *(mm/dd/yyyy)* |
|---|---|---|
| | | |

## SECTION 6: How to Submit this Form

**Mail:**
MetLife Disability
PO Box 14590
Lexington KY 40512-4590

**Fax:**
1-800-230-9531