

Please fax the completed form to:

Fax Number: 518-869-2317

New York State Nurses Association Benefits Fund P.O. Box 12-430 Albany, NY 12212

5 HH9 B8 -B; 'D<MG7 5 BfS GH5 H9A 9BH!' PROGRESS REPORT (For Mental Health Claims)



To Be Completed By The Employee

Patient Name: Date of Birth: Insured ID Number:

Patient Address: (Street, City, State & Zip Code)

To be completed by the Provider - Use current information from your patient's most recent office visit or examination to complete this form.

Is the condition related to environmental and/or interpersonal issues in his/her workplace? Yes No

If "Yes," explain:

If yes, can he / she perform the same job at a different location / employer? Yes No

Are these issues causing a disincentive to return to work with current Employer? Yes No

DIAGNOSIS:

Primary Condition: DSM or ICD Code:

Secondary Condition: DSM or ICD Code:

Patient Assessment Measures

WHODAS Score:

Domain I Domain II Domain III Domain IV Domain V Domain VI

(Provide completed assessment questionnaire)

Other Assessment Measures - please list the measure scale and provide score (attach test results):

Current Self Reported Symptoms:

Current Observed Symptoms (Clinical presentation, frequency, severity, examples):

CURRENT MENTAL STATUS EXAMINATION

(Please circle or check current status or explain in "Comments")

Examination Date:

Table with 3 columns: Category, Description, Comments. Rows include Appearance, Attitude, Speech, Thought Process, Mood, Affect, Insight into illness, Psychomotor Activity.

Table with 3 columns: Category, Description, Please check the statement that indicates how this was assessed? Rows include Attention, Concentration, Memory.

STATUS (Please check one): In remission Improved Unchanged Retrogressed

Please provide a description of the most significant recent improvement and/or decompensation:

Patient Name: _____

Date of Birth: _____

Insured ID Number: _____

FUNCTIONALITY

Did you recommend your patient stop working? Yes No If Yes, on what date? _____

Are the symptoms of such severity to preclude the patient from social/occupational functioning? Yes No

If Yes, specify what activities are impaired and how: _____

What is the expected duration of any work activity impairments? _____

Have you discussed a return to work goal with your patient? Yes No If No, please explain: _____

What are your patient's current abilities? What type of work can your patient perform? _____

What is your target date for return to work for your patient? _____ Full time Part time

If part time, on what date will your patient be able to increase to full time? _____

If appropriate, provide examples of accommodations that would allow your patient to return to work: _____

Additional comments: _____

In your opinion is the patient competent to endorse checks and direct the use of the proceeds thereof? Yes No

TREATMENT

Current Treatment Plan: _____

Date you first treated this patient for any condition: _____ Date you first treated this patient for this condition: _____

Frequency of treatment _____ List relevant treatment dates: _____

Date of last office visit: _____ Date of next scheduled office visit: _____

Medications (indicate any changes/adjustments including dosage since last report): _____

Response to medication: _____

Has patient been referred to other mental health providers/physicians since last report? Yes No

If "yes", are you coordinating care with this provider(s)? Yes No Date of Referral(s): _____

Referral Provider Name	Phone Number: ()	Specialty:
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Was patient hospitalized or treated at a higher level of care for this condition since the last report? Yes No

If "yes", please provide information about any higher level of care since last report:

Inpatient: Hospital/facility name _____ Phone Number: ()

Admission date: _____ Discharge date: _____

Partial Hospital/Day Treatment/IOP: Hospital/facility name _____ Phone Number: ()

Admission date: _____ Discharge date: _____ Number of days per week: _____ Number of hours per day: _____

Residential: Facility name: _____ Phone Number: ()

Admission date: _____ Discharge date: _____

PROVIDER'S INFORMATION

Provider's Name: _____ Telephone number: ()

Address: (Street, City, State & Zip Code) _____ Fax Number: ()

Degree: _____ Specialty: _____ Social Security Number or EIN Number: _____ License Number: _____

Office Contact: _____ Office Contact Phone ()

Provider's Signature: _____ Date Signed: _____

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