Employment Development Department
State of California

EDD
State Disability Evaluations: Role for Orthopaedic Surgeons and SDI Online

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Medical Director

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Overview

* SDI Basics
* Legal Basis
* IME definition and logistics
* IME Provider Applications and Agreements
* SDI Online
  * Sign up
  * Use

What is SDI?

* Short-term disability insurance plan for approximately 13 million California workers
* Employee paid
* Waiting period of only seven days
* Partial wage replacement up to approximately 55% of the highest quarter in the base period

Disability Insurance (DI) Compared to Paid Family Leave (PFL)

Disability Insurance	Paid Family Leave
Up to 52 weeks per claim	Up to six weeks per 12-months
Employee's personal illness, injury, or disability	Caring for a seriously ill family member or to bond with a new child
Not required to use vacation benefits	Employers *may* require employees to use up to two weeks of vacation
Vacation pay is not in conflict with DI	Vacation pay conflicts with PFL when employer requires employee to use
Benefits are not reportable to IRS (unless in lieu of UI)	Benefits are reportable to IRS

Disability Legal Basis

* California Unemployment Insurance Code (CUIC)
  * Disability=illness or injury, physical or mental which prevents performance of regular or customary work
* California Code of Regulations Title 22

IME Legal Basis

* Title 22 section 2627(c) -1 must be reasonable as evidenced by one of the following circumstances:
  * Medical information from the physician does not justify length of time excused in a first claim or extension
  * Conflicting medical evidence from different physicians
  * Claimant's activities in conflict with reported disability
  * Additional information is necessary to confirm disability

How is a Panelist Chosen?

* By SDI staff from a database: IMELS

* Clinical Specialty
* Geographic proximity
* Language needs
* Subspecialty
* Lack of complaints

IME Timing

* Claimant mailed IME Provider's information
* They must make appointment within seven days
* Appointment must occur at earliest possible date
* IME Panelist provided
  * Identifying information
  * ICD codes
  * Date disability began

CA SDI IME Requirements

* Not a consultation per Title 22
* Differs from IME's for other agencies

* 1) Ability to perform regular or customary work (occupational history required)
* 2) When return to work expected

Ancillary Studies

* Claimant asked to bring prior work which should be evaluated and noted in the record, but no separate charge done
* New studies can only be as extensive required to determine ability to work
* Bills for over $200 in tests requires preapproval
* Prices are being re-evaluated

Charges

* Recent attempt to increase rejected at high level
* Will try again in the future
* Very limited IME
* Non Board Certified $83.30
* Board Certified $138.55
* Payee Data Record (State form STD 204) required
* Invoice form DE 2546INV

Confidentiality

* CUIC section 2714 requires confidentiality
* Not required to maintain a copy
* If you do save a copy it must be separate from other records
* Any requests for report copies should be referred to the Field Office that requested the IME

Clinical Issues Arising in IME

* Previously undiagnosed significant medical condition
  * Inform claimant of suspicion
  * Ask them to seek attention from their medical provider
* Do not treat or prescribe
* Do not refer to another provider
* Do not express opinions about care by others

Application & Agreement Forms

* Private practice setting
  * Application (DE 2546D)
  * Agreement (DE 2546SA)

* Clinic setting
  * Clinic Application (DE 2546DC)
  * Clinic Agreement (DE 2546CSA)
  * Provider Application (DE 2546CS)

Provider Documentation

* Current license (photocopy)
* Current curriculum vitae
* Current professional liability insurance proof
* Appropriate application
  * Private practice
  * Clinic setting

Clinic or Private Practice Office

* General liability insurance proof naming EDD as additional insured (this is done for no charge)
* Workers' compensation insurance proof
* Payee data record (State form STD 204)
* Appropriate SDI agreement
  * Private practice
  * Clinic

Acceptance to Panel

* Application, agreement and documentation evaluated by the Medical Director
* Upon acceptance
  * Notification sent out
  * Information added to IMELS database

NEW! SDI Online

Newly Introduced – SDI Online

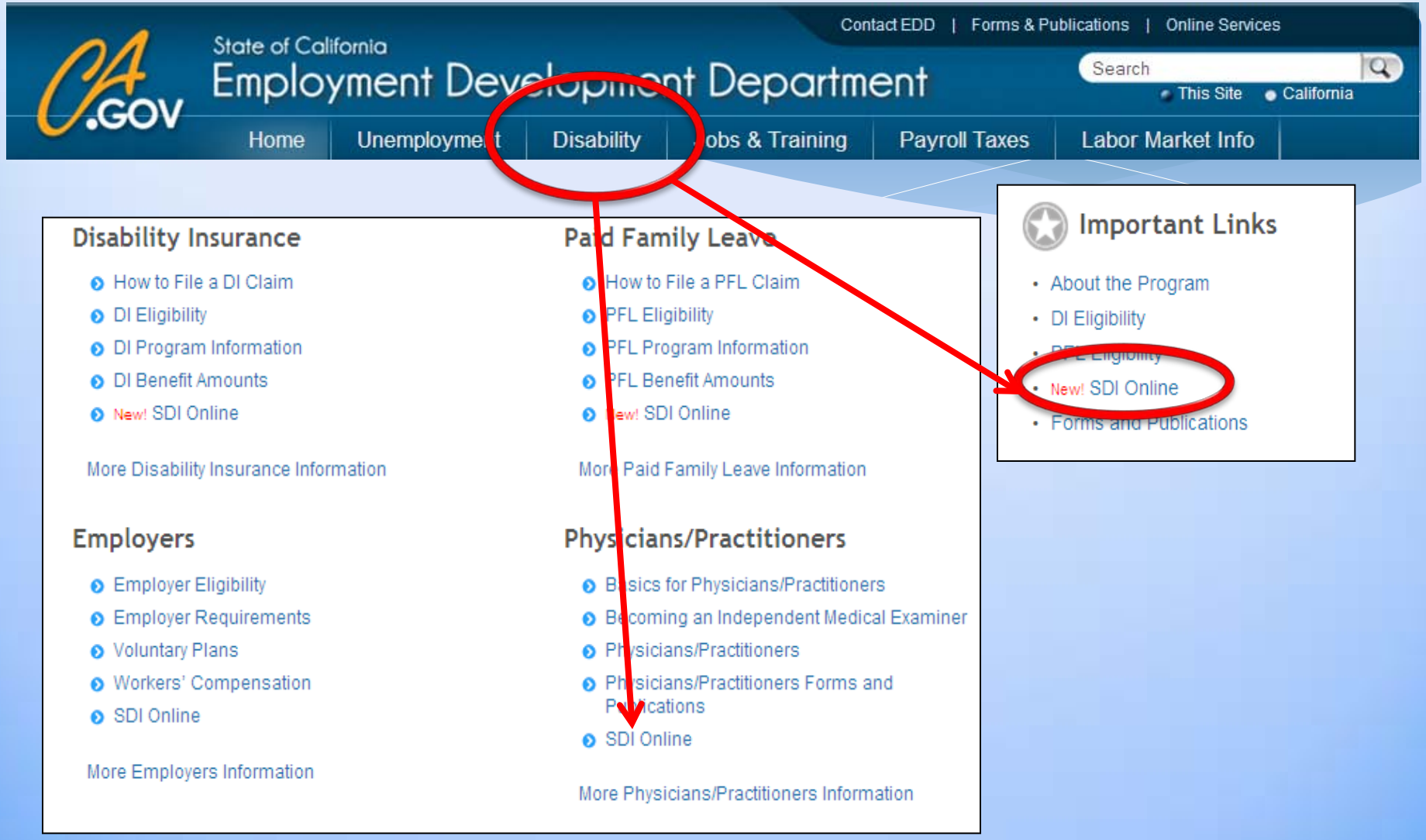
* State Disability Insurance (SDI) Online is an electronic claim filing system, for claimants, employers, physician/practitioners, and voluntary plans.
* Option to create an online account and submit Disability Insurance and Paid Family Leave claims information electronically.

NEW! SDI Online

SDI Online continued-

* Physician/practitioners are able to electronically certify to their patients' disability and submit patient's medical information through this secure online site.
* **Note:** paper forms will still be available in a new Optical Character Recognition (OCR) version which can be processed through SDI Online.

Create an SDI Online Account


Contact EDD | Forms & Publications | Online Services
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This Site
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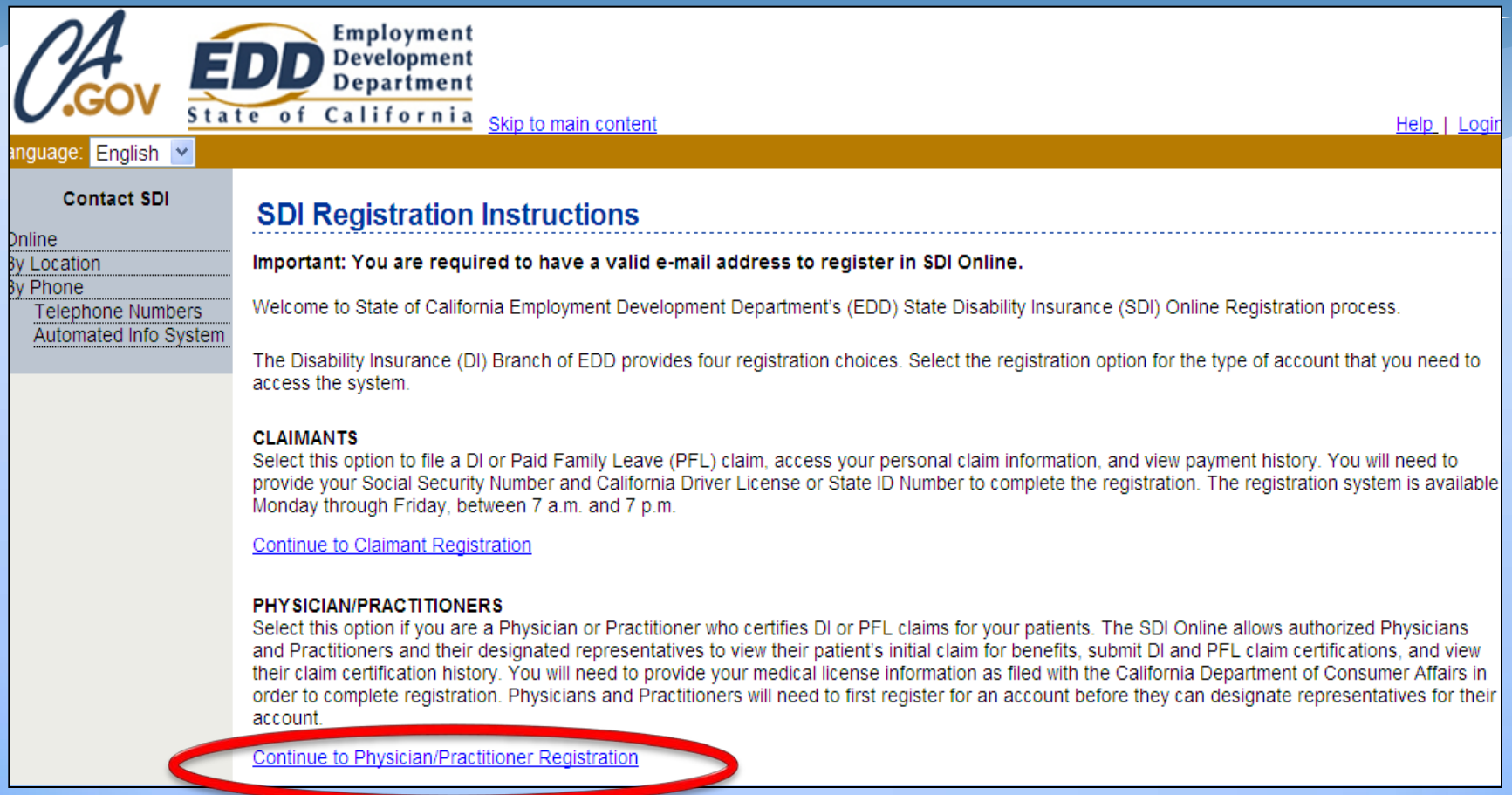
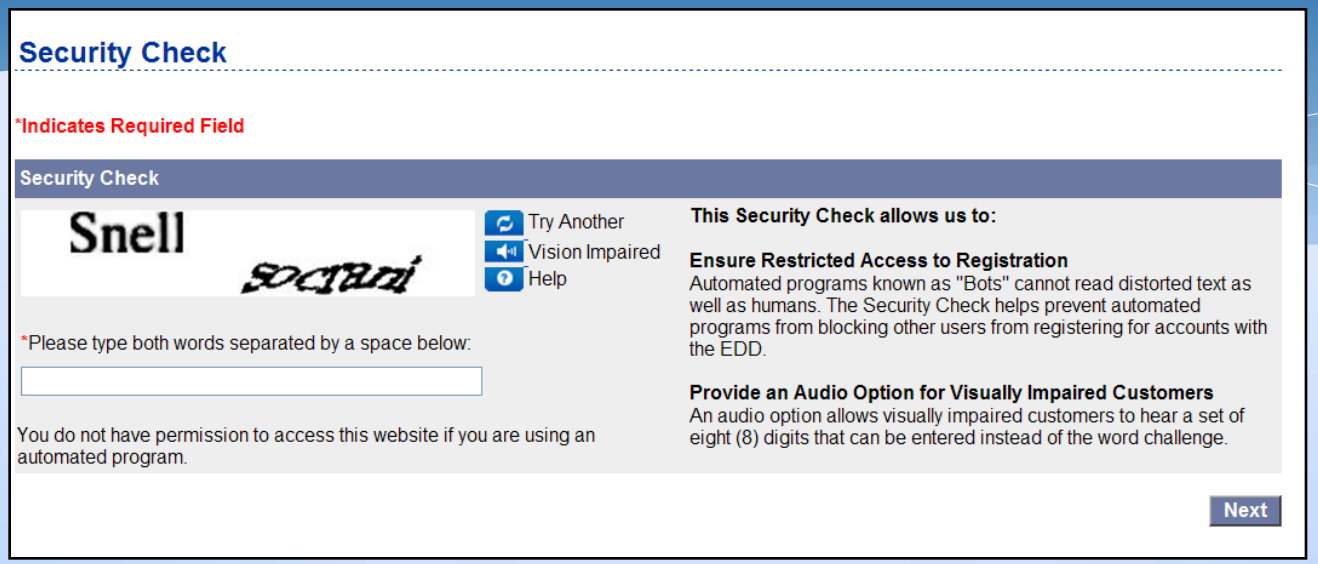
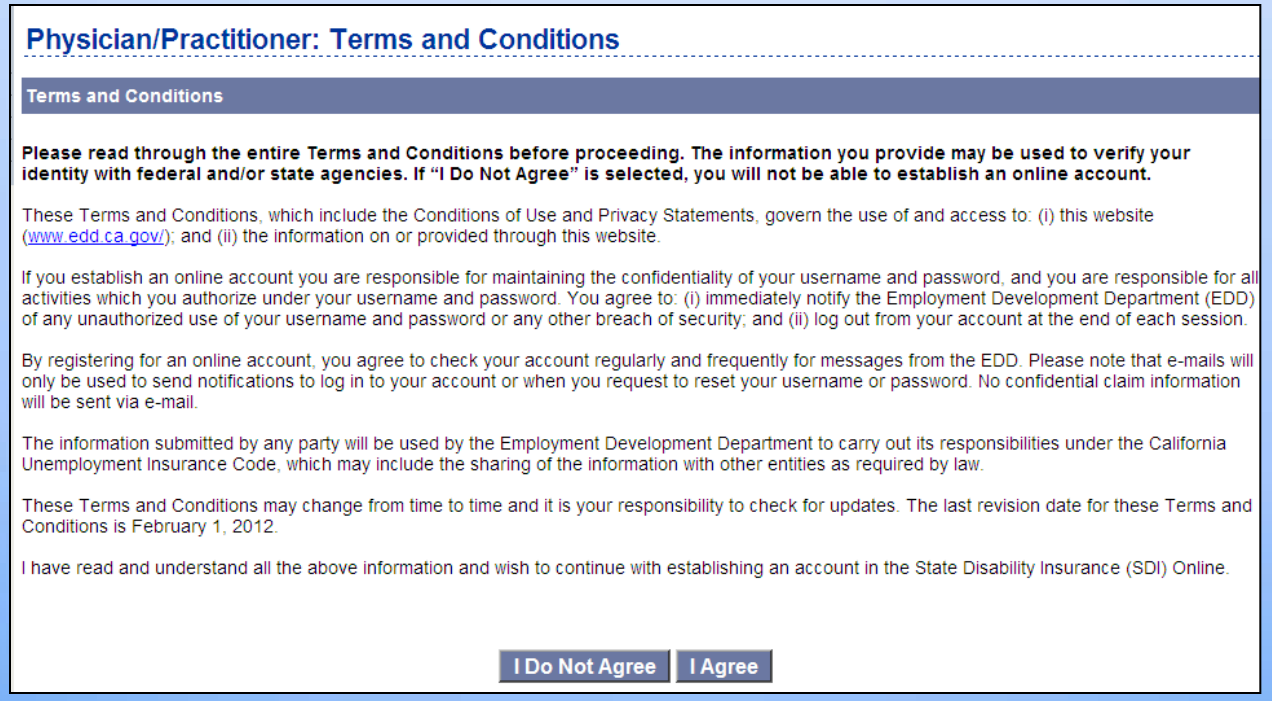
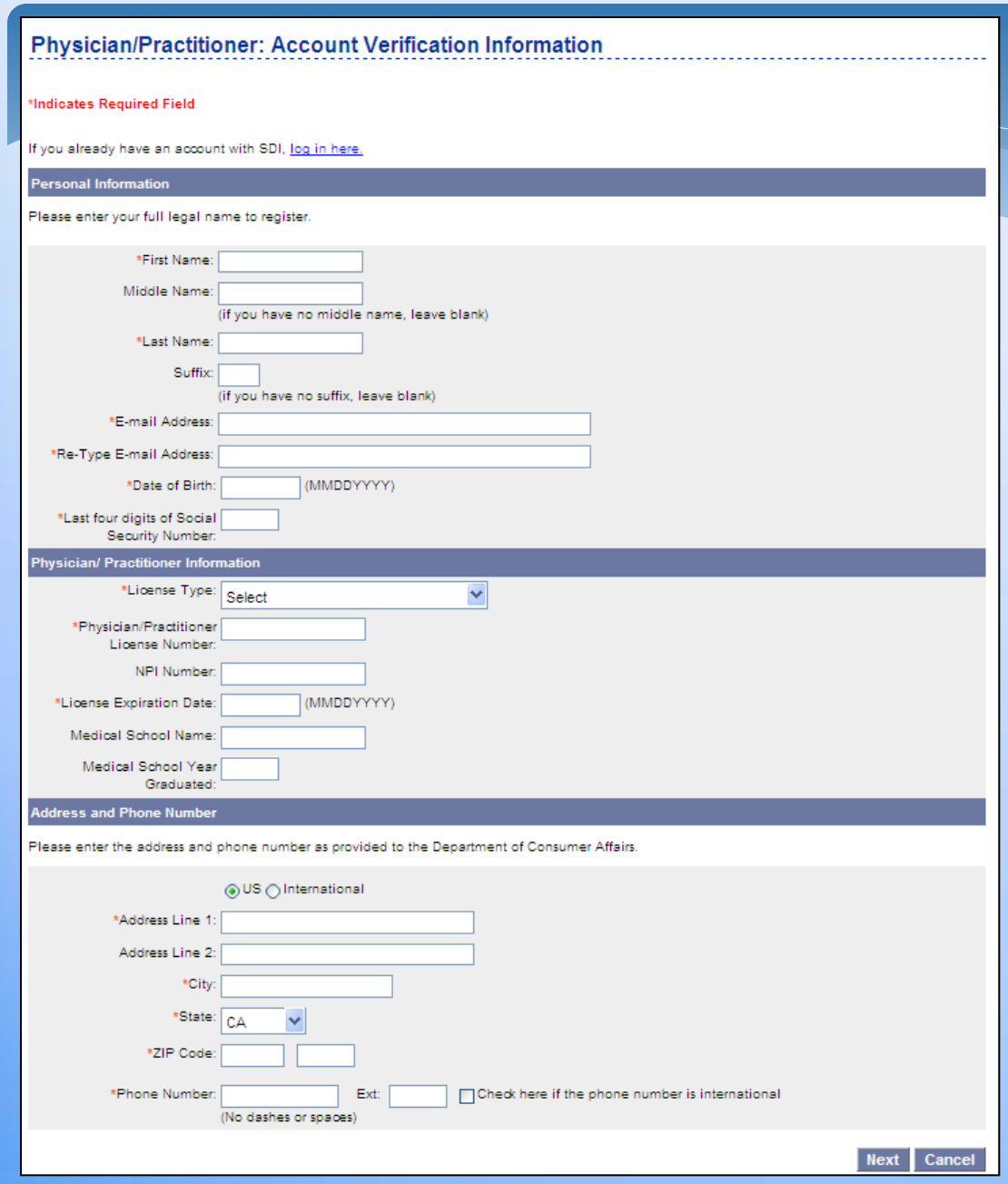
Unemployment
Disability
Jobs & Training
Payroll Taxes
Labor Market Info
Disability Insurance
How to File a DI Claim
DI Eligibility
DI Program Information
DI Benefit Amounts
New! SDI Online
More Disability Insurance Information
Paid Family Leave
How to File a PFL Claim
PFL Eligibility
PFL Program Information
PFL Benefit Amounts
New! SDI Online
More Paid Family Leave Information
Employers
Employer Eligibility
Employer Requirements
Voluntary Plans
Workers' Compensation
SDI Online
More Employers Information
Physicians/Practitioners
Basics for Physicians/Practitioners
Becoming an Independent Medical Examiner
Physicians/Practitioners
Physicians/Practitioners Forms and Publications
SDI Online
More Physicians/Practitioners Information
Important Links
About the Program
DI Eligibility
New! SDI Online
Forms and Publications


Employment Development Department
State of California
Skip to main content
Help | Login
anguage: English
Contact SDI
Online
By Location
By Phone
Telephone Numbers
Automated Info System
SDI Registration Instructions
Important: You are required to have a valid e-mail address to register in SDI Online.
Welcome to State of California Employment Development Department's (EDD) State Disability Insurance (SDI) Online Registration process.
The Disability Insurance (DI) Branch of EDD provides four registration choices. Select the registration option for the type of account that you need to access the system.
CLAIMANTS
Select this option to file a DI or Paid Family Leave (PFL) claim, access your personal claim information, and view payment history. You will need to provide your Social Security Number and California Driver License or State ID Number to complete the registration. The registration system is available Monday through Friday, between 7 a.m. and 7 p.m.
Continue to Claimant Registration
PHYSICIAN/PRACTITIONERS
Select this option if you are a Physician or Practitioner who certifies DI or PFL claims for your patients. The SDI Online allows authorized Physicians and Practitioners and their designated representatives to view their patient's initial claim for benefits, submit DI and PFL claim certifications, and view their claim certification history. You will need to provide your medical license information as filed with the California Department of Consumer Affairs in order to complete registration. Physicians and Practitioners will need to first register for an account before they can designate representatives for their account.
Continue to Physician/Practitioner Registration


Security Check
*Indicates Required Field
Security Check
Snell
Try Another
Vision Impaired
Help
*Please type both words separated by a space below:
You do not have permission to access this website if you are using an automated program.
This Security Check allows us to:
Ensure Restricted Access to Registration
Automated programs known as "Bots" cannot read distorted text as well as humans. The Security Check helps prevent automated programs from blocking other users from registering for accounts with the EDD.
Provide an Audio Option for Visually Impaired Customers
An audio option allows visually impaired customers to hear a set of eight (8) digits that can be entered instead of the word challenge.
Next


Physician/Practitioner: Terms and Conditions
Terms and Conditions
Please read through the entire Terms and Conditions before proceeding. The information you provide may be used to verify your identity with federal and/or state agencies. If "I Do Not Agree" is selected, you will not be able to establish an online account.
These Terms and Conditions, which include the Conditions of Use and Privacy Statements, govern the use of and access to: (i) this website (www.edd.ca.gov/); and (ii) the information on or provided through this website.
If you establish an online account you are responsible for maintaining the confidentiality of your username and password, and you are responsible for all activities which you authorize under your username and password. You agree to: (i) immediately notify the Employment Development Department (EDD) of any unauthorized use of your username and password or any other breach of security; and (ii) log out from your account at the end of each session.
By registering for an online account, you agree to check your account regularly and frequently for messages from the EDD. Please note that e-mails will only be used to send notifications to log in to your account or when you request to reset your username or password. No confidential claim information will be sent via e-mail.
The information submitted by any party will be used by the Employment Development Department to carry out its responsibilities under the California Unemployment Insurance Code, which may include the sharing of the information with other entities as required by law.
These Terms and Conditions may change from time to time and it is your responsibility to check for updates. The last revision date for these Terms and Conditions is February 1, 2012.
I have read and understand all the above information and wish to continue with establishing an account in the State Disability Insurance (SDI) Online.
I Do Not Agree
I Agree



Physician/Practitioner: Account Verification Information

*Indicates Required Field

If you already have an account with SDI, log in here.

Personal Information

Please enter your full legal name to register.

*First Name:

Middle Name:
(if you have no middle name, leave blank)

*Last Name:

Suffix:
(if you have no suffix, leave blank)

*E-mail Address:

*Re-Type E-mail Address:

*Date of Birth: (MMDDYYYY)

*Last four digits of Social Security Number:

Physician/ Practitioner Information

*License Type: Select

*Physician/Practitioner License Number:

NPI Number:

*License Expiration Date: (MMDDYYYY)

Medical School Name:

Medical School Year Graduated:

Address and Phone Number

Please enter the address and phone number as provided to the Department of Consumer Affairs.

US International

*Address Line 1:

Address Line 2:

*City:

*State: CA

*ZIP Code:

*Phone Number: Ext: Check here if the phone number is international
(No dashes or spaces)

Next Cancel

Physician/Practitioner: Setup Security Profile Information

*Indicates Required Field

Account Information

Enter a Username and Password. Do not share your password with anyone.

*Username:
(must be 6 to 15 characters, no special characters)

*Password: (case sensitive)
(must be 8 to 12 characters long, including an uppercase letter, a lowercase letter, a number, and one of the following: ! @ # $ % ^ & * ( ))

*Re-Type Password: (case sensitive)

*Password Hint:

Choose your Security Questions and enter your answer to each question. This will be part of your Account Recovery Options.

*Question 1: Please select your question

*Answer to Question 1:

*Question 2: Please select your question

*Answer to Question 2:

*Question 3: Please select your question

*Answer to Question 3:

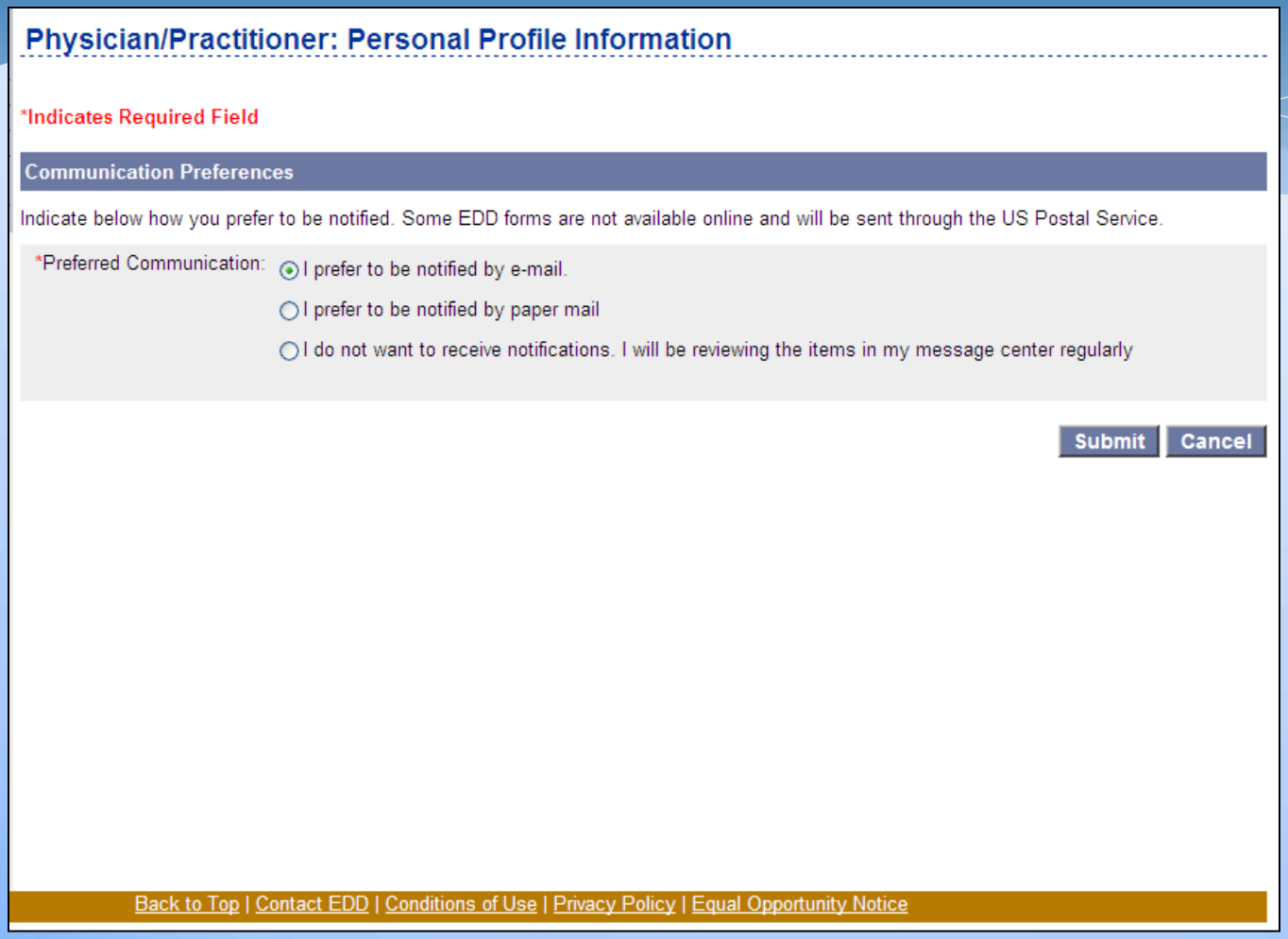
*Question 4: Please select your question

*Answer to Question 4:

*Choose your Personal Image and enter a Personal Image Caption for it. The image along with your image caption helps you know that you are at a valid EDD site and that it is safe to enter information. Refresh to get a new set of personal images.

*Personal Image Caption:

Next Cancel


Physician/Practitioner: Personal Profile Information
*Indicates Required Field
Communication Preferences
Indicate below how you prefer to be notified. Some EDD forms are not available online and will be sent through the US Postal Service.
*Preferred Communication:
I prefer to be notified by e-mail.
I prefer to be notified by paper mail
I do not want to receive notifications. I will be reviewing the items in my message center regularly
Submit
Cancel
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Account Setup Confirmation

Successful Account Creation Notification

Your account has been created and your EDD Customer Account Number is A notification has been sent to you via e-mail. If you do not receive an email, please check your junk/spam folder. To ensure e-mails from the EDD appear in your inbox, add noreply@edd.ca.gov to your address book.

Login

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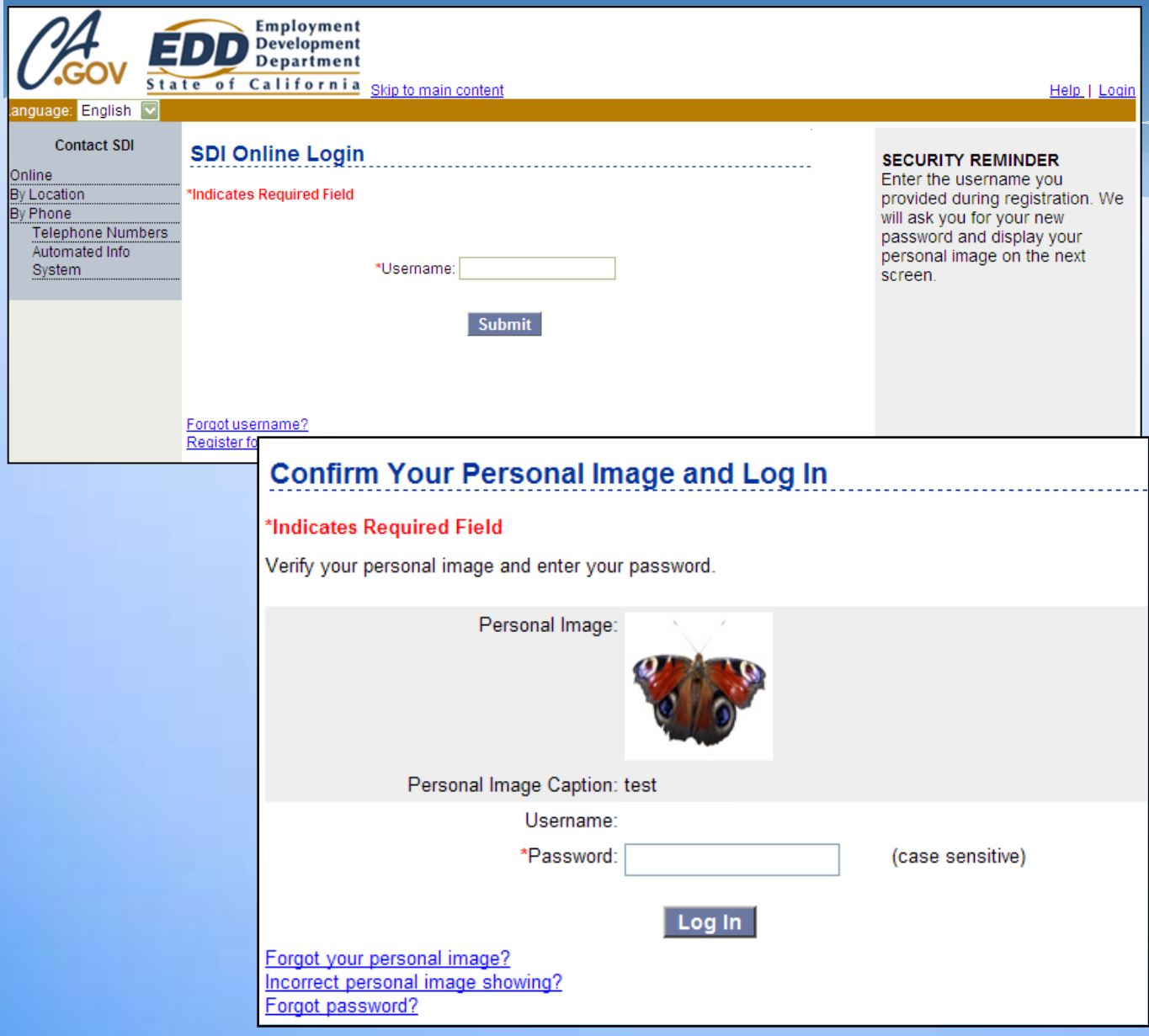
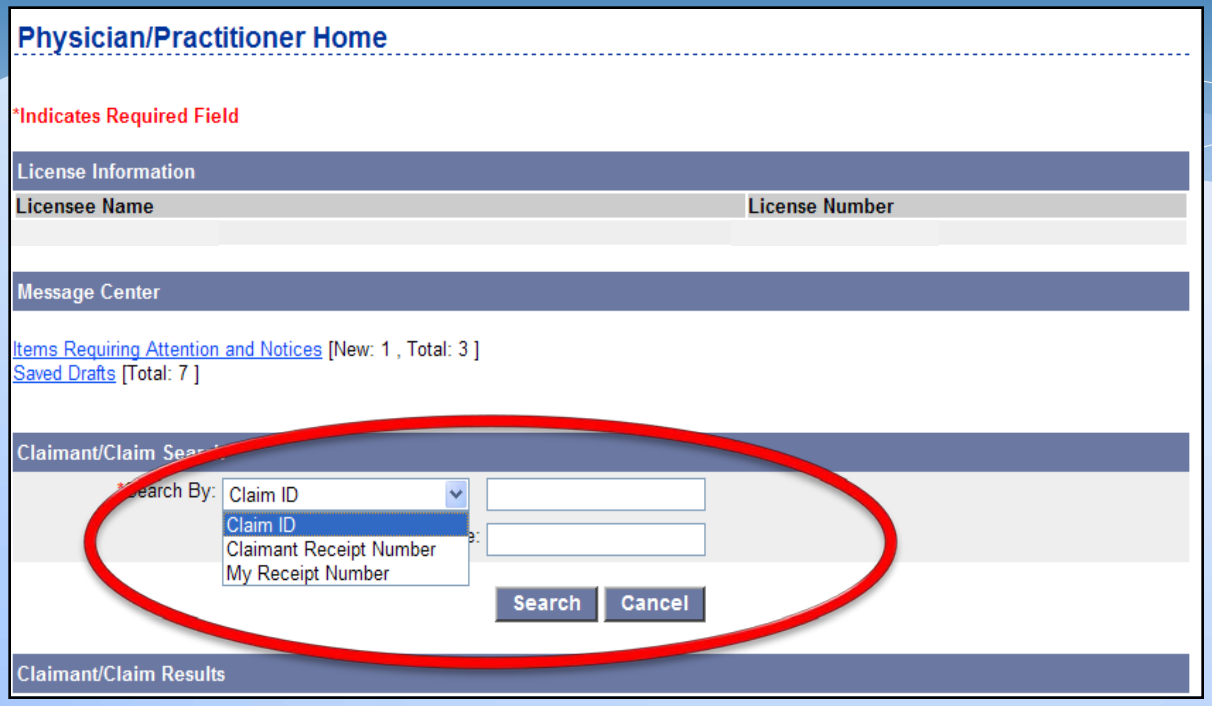
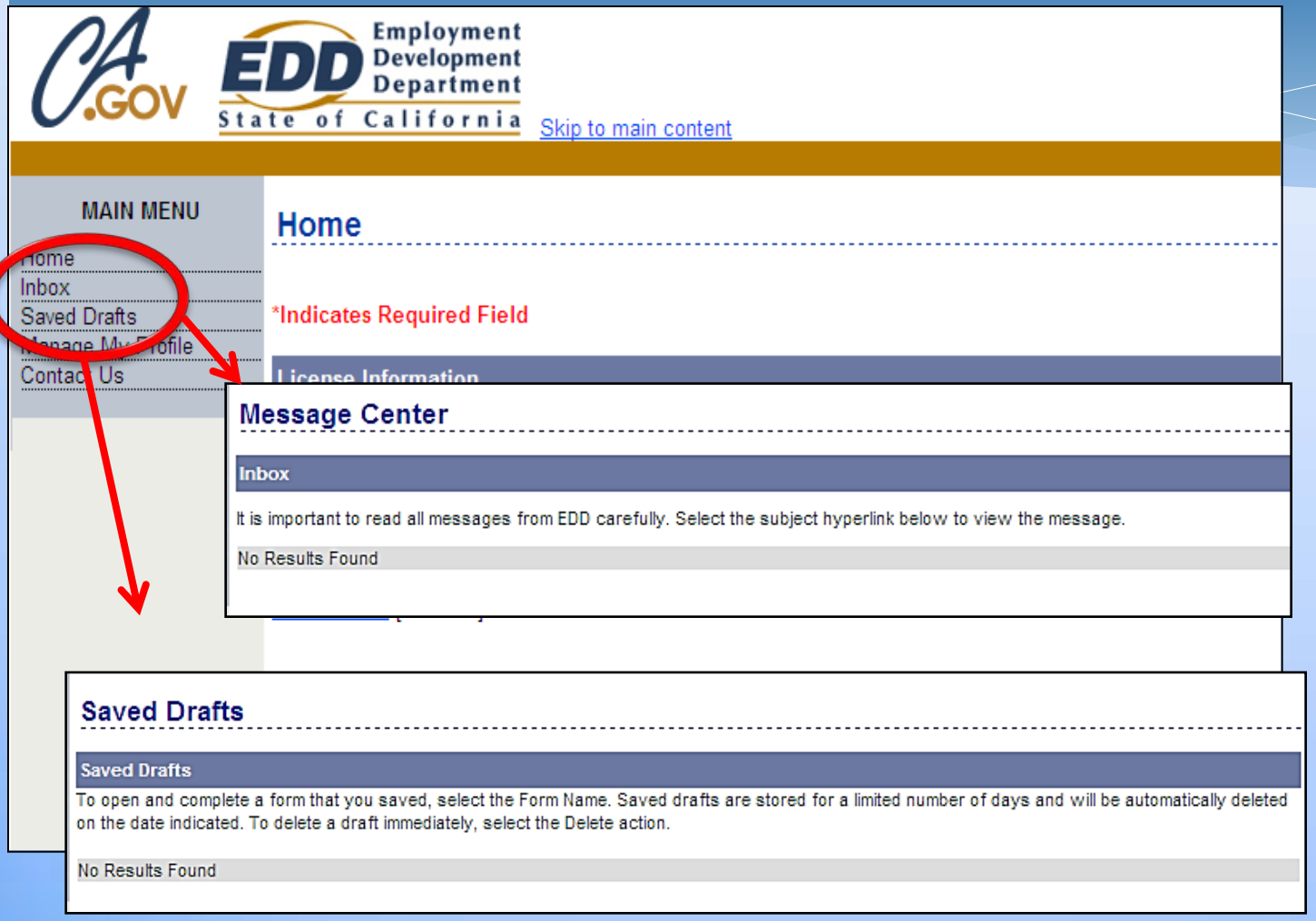
Access SDI Online Accounts


Employment Development Department
State of California
Skip to main content
Help | Login
anguage: English
Contact SDI
Online
By Location
By Phone
Telephone Numbers
Automated Info System
SDI Online Login
*Indicates Required Field
*Username:
Submit
Forgot username?
SECURITY REMINDER
Enter the username you provided during registration. We will ask you for your new password and display your personal image on the next screen.
Confirm Your Personal Image and Log In
*Indicates Required Field
Verify your personal image and enter your password.
Personal Image:
Personal Image Caption: test
Username:
*Password:
(case sensitive)
Log In
Forgot your personal image?
Incorrect personal image showing?
Forgot password?


Physician/Practitioner Home
*Indicates Required Field
License Information
Licensee Name
License Number
Message Center
Items Requiring Attention and Notices [New: 1 , Total: 3]
Saved Drafts [Total: 7]
Claimant/Claim Sea
Search By:
Claim ID
Claim ID
Claimant Receipt Number
My Receipt Number
Search
Cancel
Claimant/Claim Results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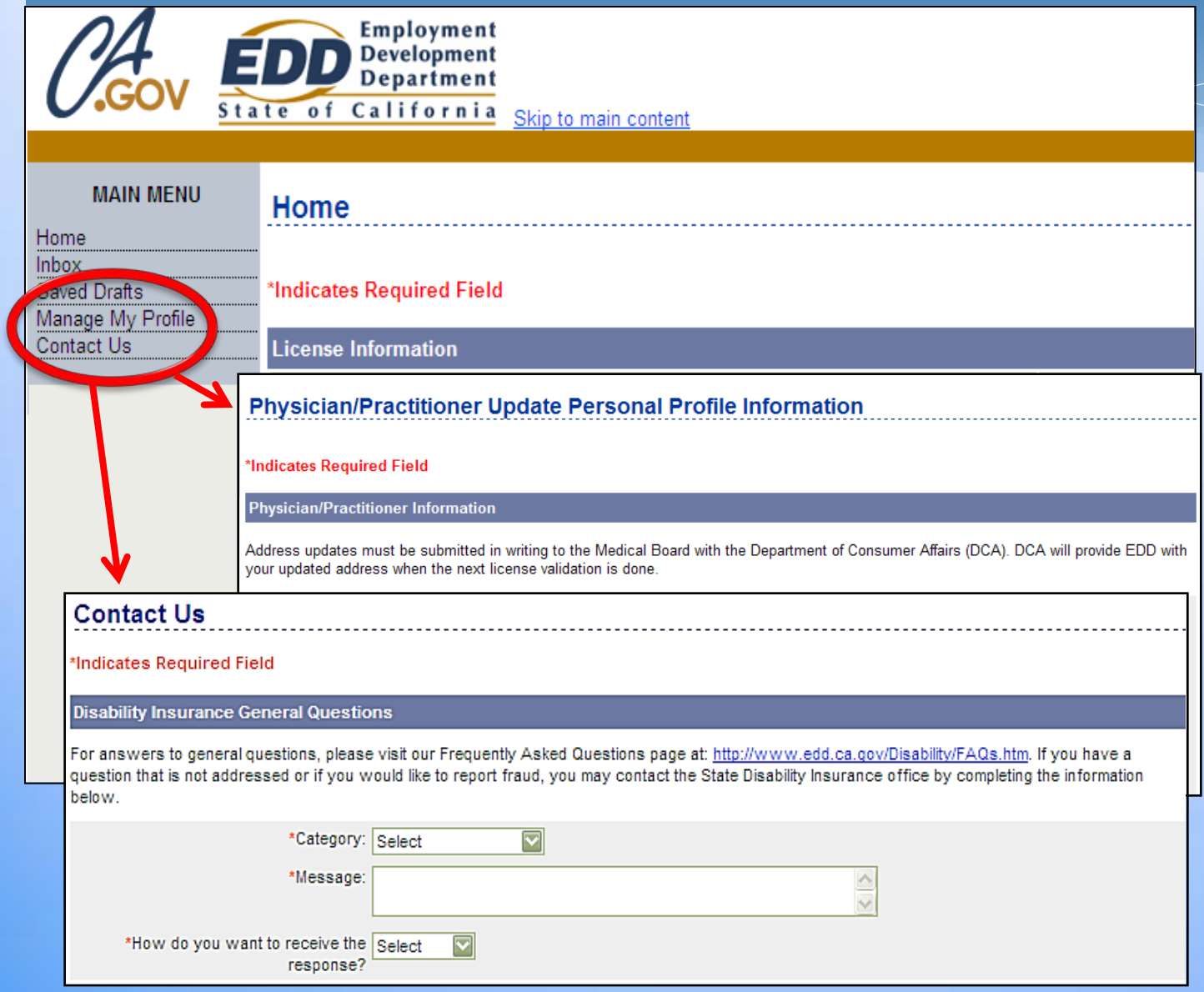
Skip to main content
MAIN MENU
Home
Inbox
Saved Drafts
Contact Us
Home
*Indicates Required Field
Message Center
Inbox
It is important to read all messages from EDD carefully. Select the subject hyperlink below to view the message.
No Results Found
Saved Drafts
Saved Drafts
To open and complete a form that you saved, select the Form Name. Saved drafts are stored for a limited number of days and will be automatically deleted on the date indicated. To delete a draft immediately, select the Delete action.
No Results Found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State of California
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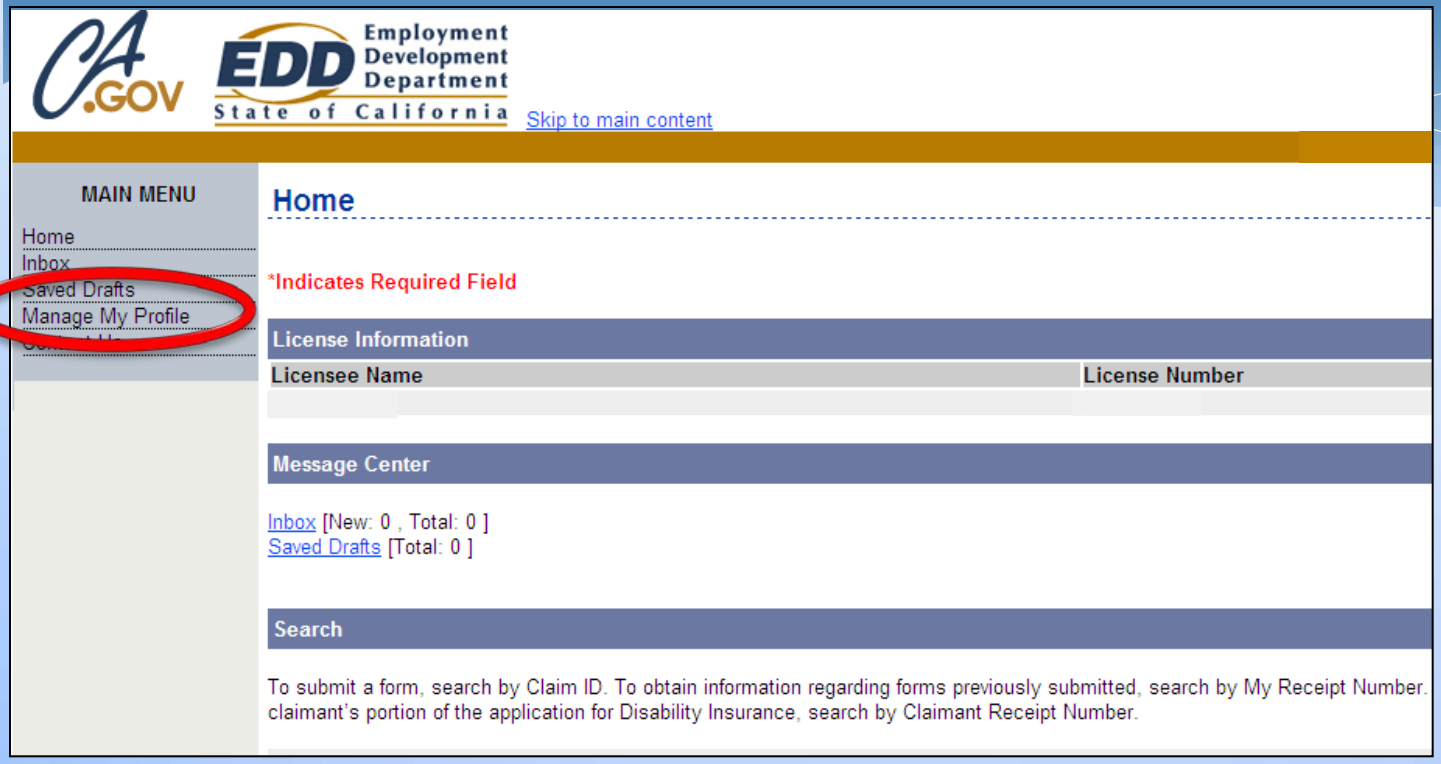
MAIN MENU
Home
Inbox
Saved Drafts
Manage My Profile
Contact Us
Home
*Indicates Required Field
License Information
Physician/Practitioner Update Personal Profile Information
*Indicates Required Field
Physician/Practitioner Information
Address updates must be submitted in writing to the Medical Board with the Department of Consumer Affairs (DCA). DCA will provide EDD with your updated address when the next license validation is done.
Contact Us
*Indicates Required Field
Disability Insurance General Questions
For answers to general questions, please visit our Frequently Asked Questions page at: http://www.edd.ca.gov/Disability/FAQs.htm. If you have a question that is not addressed or if you would like to report fraud, you may contact the State Disability Insurance office by completing the information below.
*Category: Select
*Message:
*How do you want to receive the response? Select

Add a Treatment Address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Skip to main content
MAIN MENU
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Manage My Profile
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License Information
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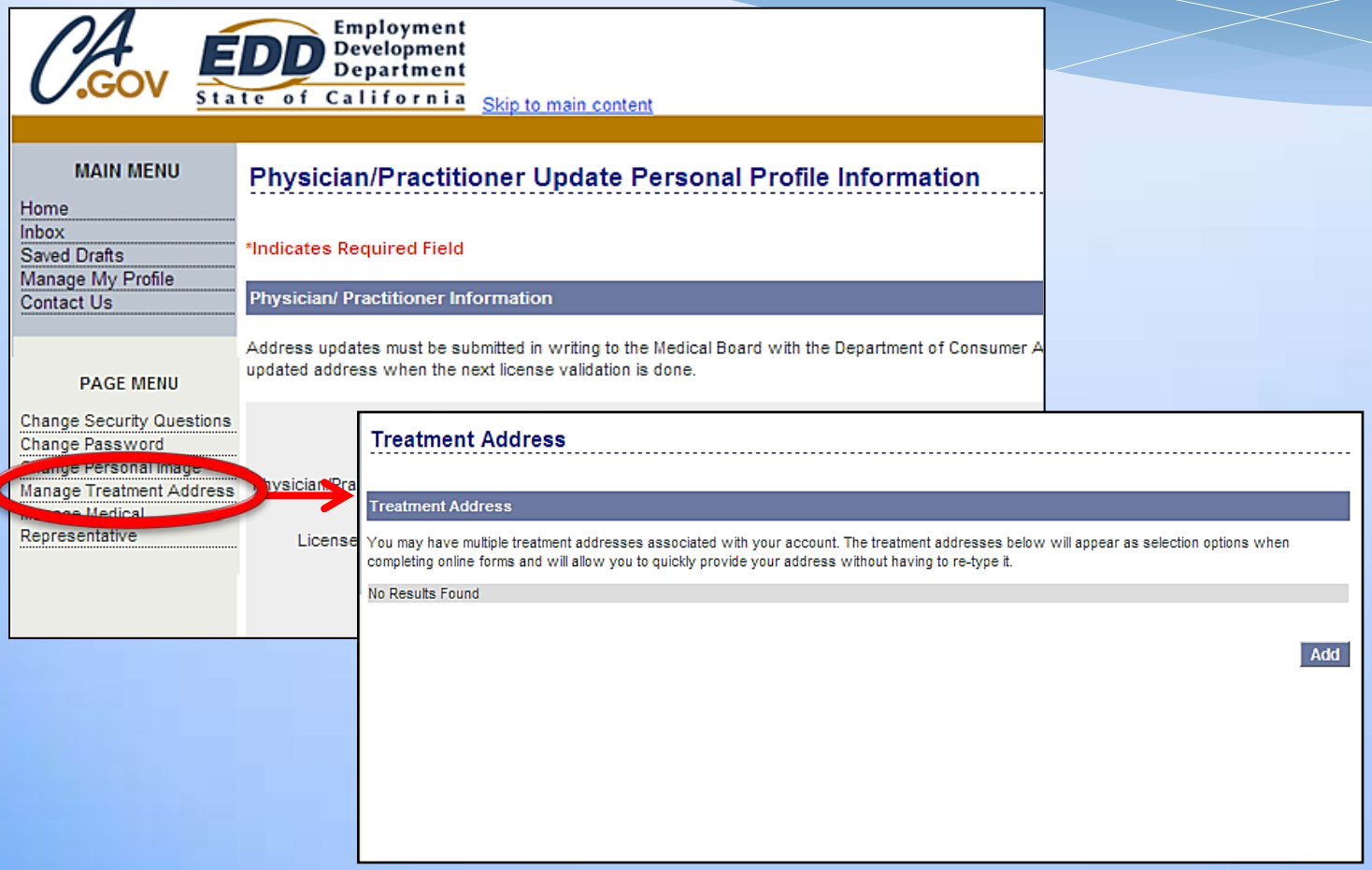
Message Center
Inbox [New: 0 , Total: 0]
Saved Drafts [Total: 0]
Search
To submit a form, search by Claim ID. To obtain information regarding forms previously submitted, search by My Receipt Number.
claimant's portion of the application for Disability Insurance, search by Claimant Receipt Number.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Home
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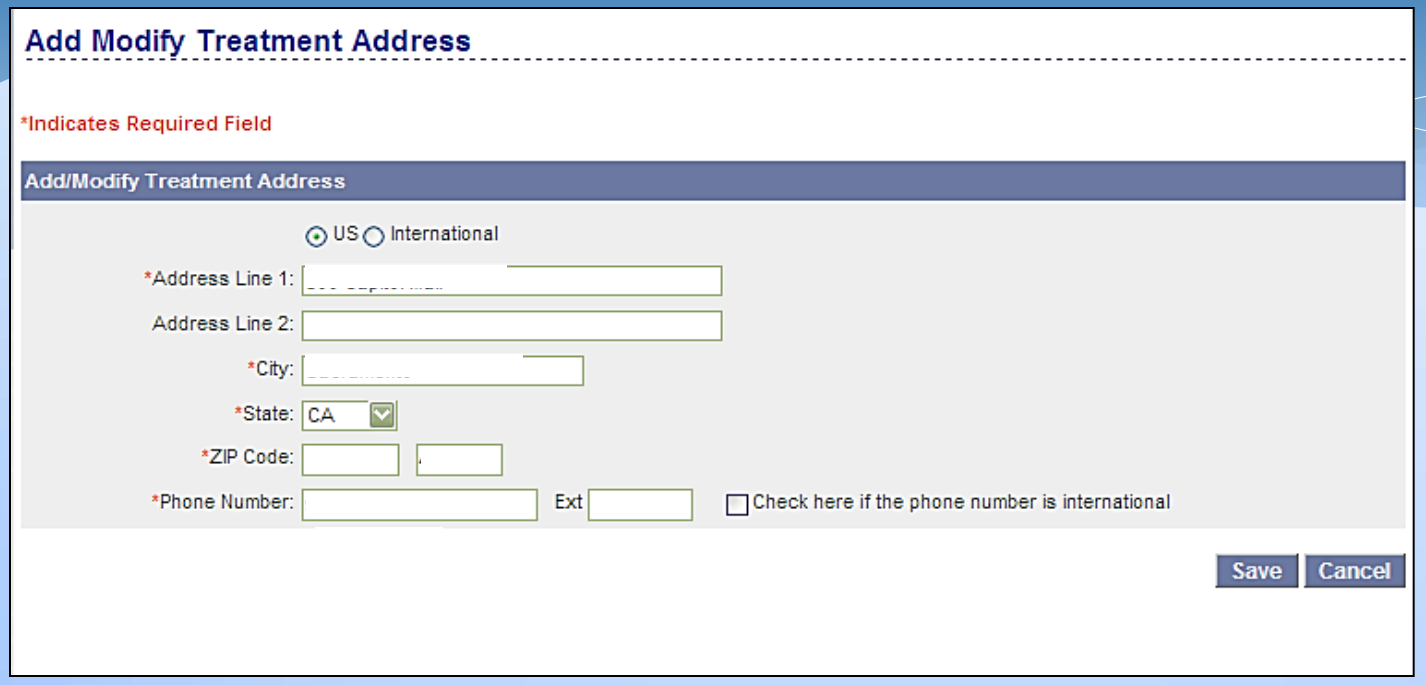
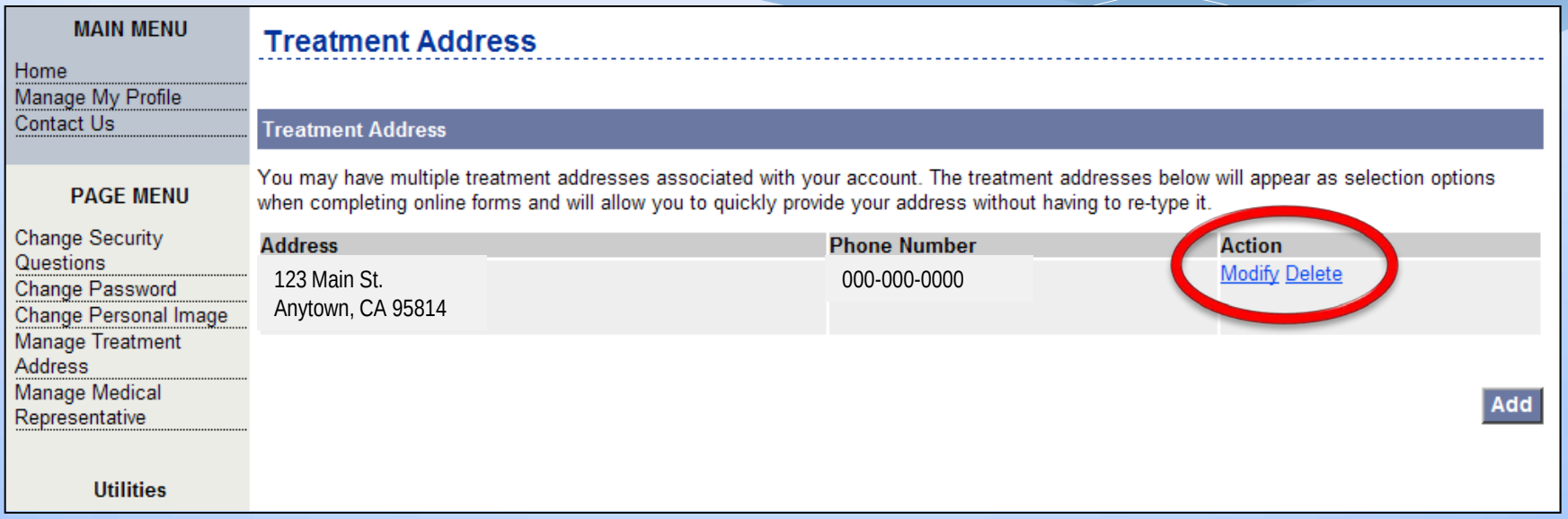
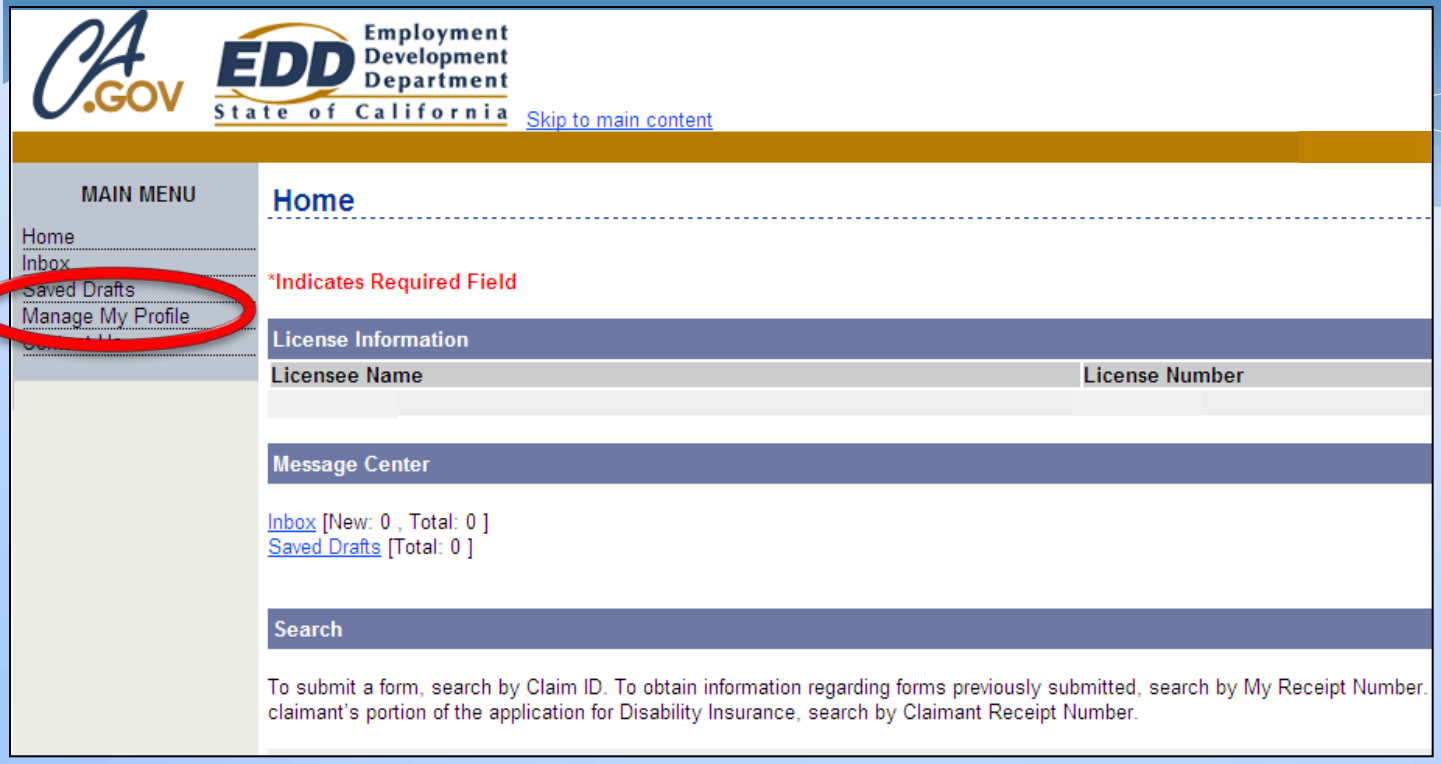
Saved Drafts
Manage My Profile
Contact Us
PAGE MENU
Change Security Questions
Change Password
Manage Treatment Address
Representative
Physician/Practitioner Update Personal Profile Information
*Indicates Required Field
Physician/ Practitioner Information
Address updates must be submitted in writing to the Medical Board with the Department of Consumer A
updated address when the next license validation is done.
License
Treatment Address
Treatment Address
You may have multiple treatment addresses associated with your account. The treatment addresses below will appear as selection options when completing online forms and will allow you to quickly provide your address without having to re-type it.
No Results Found
Add


Add Modify Treatment Address
*Indicates Required Field
Add/Modify Treatment Address
US
International
*Address Line 1:
Address Line 2:
*City:
*State:
CA
*ZIP Code:
*Phone Number:
Ext
Check here if the phone number is international
Save
Cancel


MAIN MENU
Home
Manage My Profile
Contact Us
PAGE MENU
Change Security Questions
Change Password
Change Personal Image
Manage Treatment Address
Manage Medical Representative
Utilities
Treatment Address
Treatment Address
You may have multiple treatment addresses associated with your account. The treatment addresses below will appear as selection options when completing online forms and will allow you to quickly provide your address without having to re-type it.
Address
Phone Number
Action
123 Main St.
Anytown, CA 95814
000-000-0000
Modify Delete
Add

Assign a Medical Representative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State of California
Skip to main content
MAIN MENU
Home
Inbox
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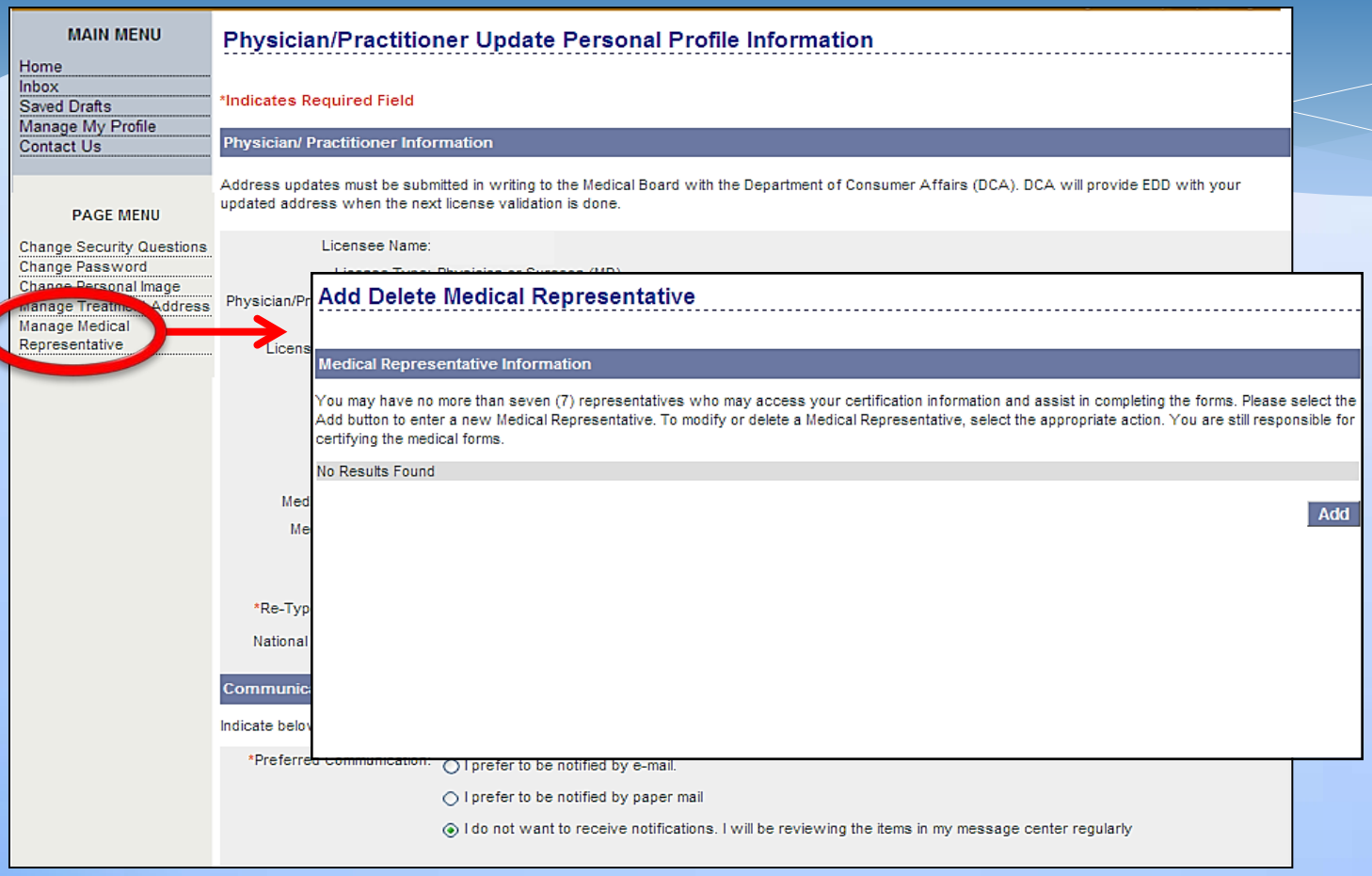
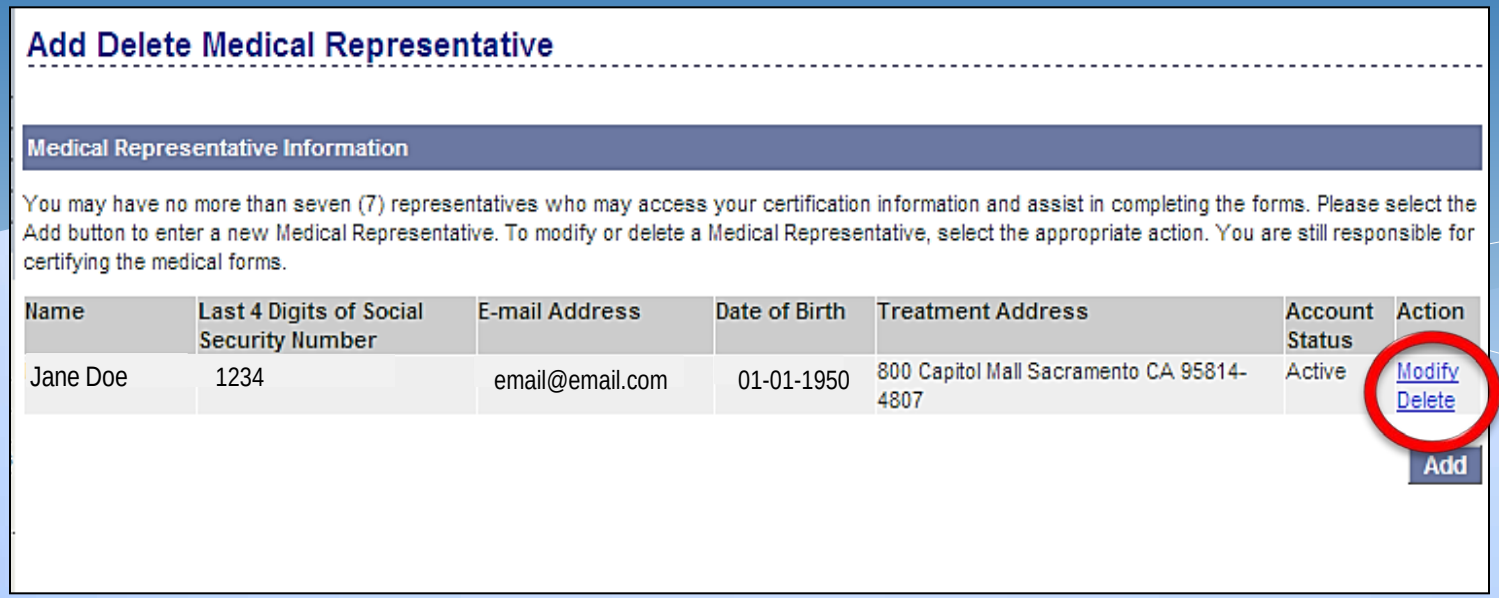
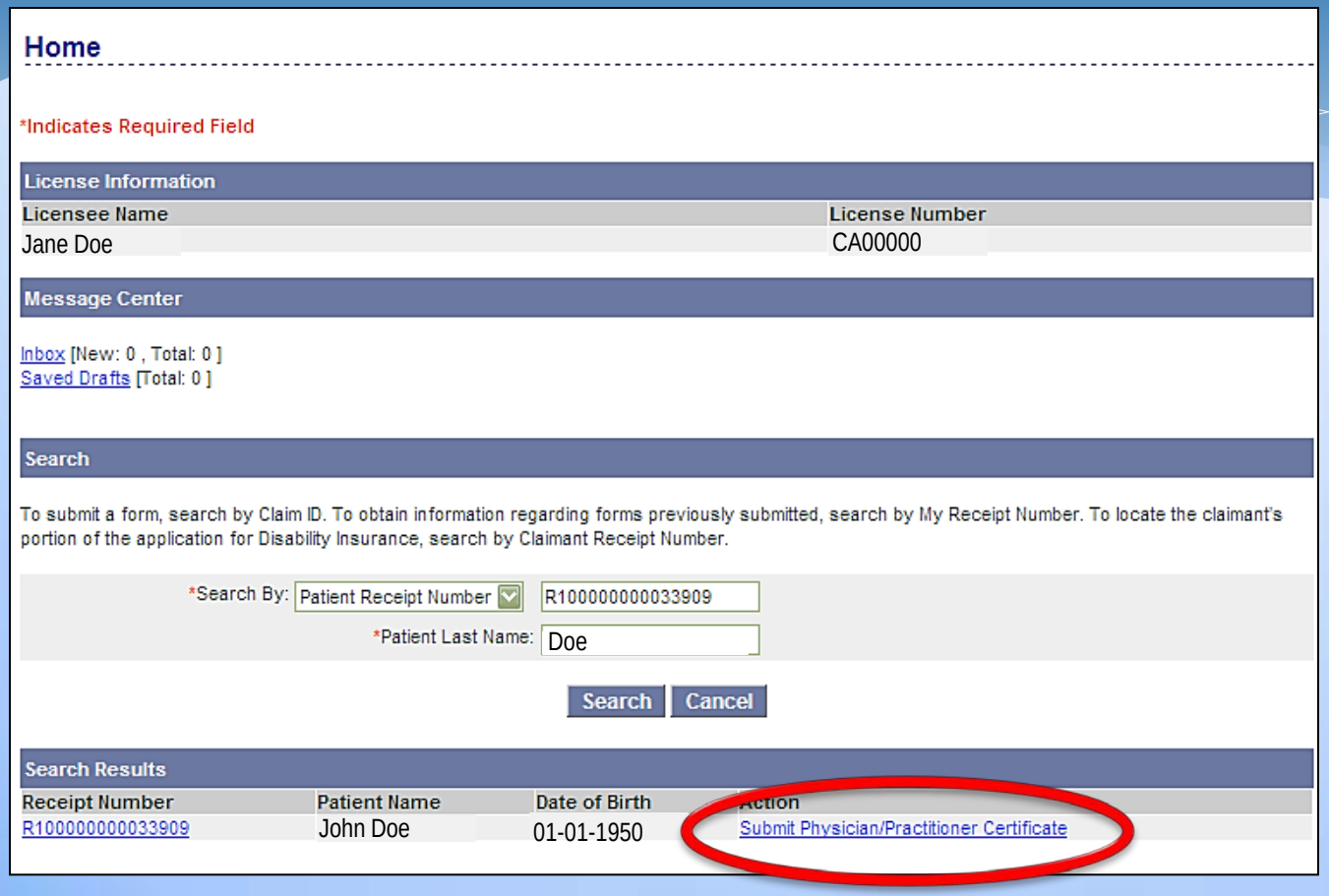
Manage My Profile
Home
*Indicates Required Field
License Information
Licensee Name
License Number
Message Center
Inbox [New: 0 , Total: 0]
Saved Drafts [Total: 0]
Search
To submit a form, search by Claim ID. To obtain information regarding forms previously submitted, search by My Receipt Number.
claimant's portion of the application for Disability Insurance, search by Claimant Receipt Number.

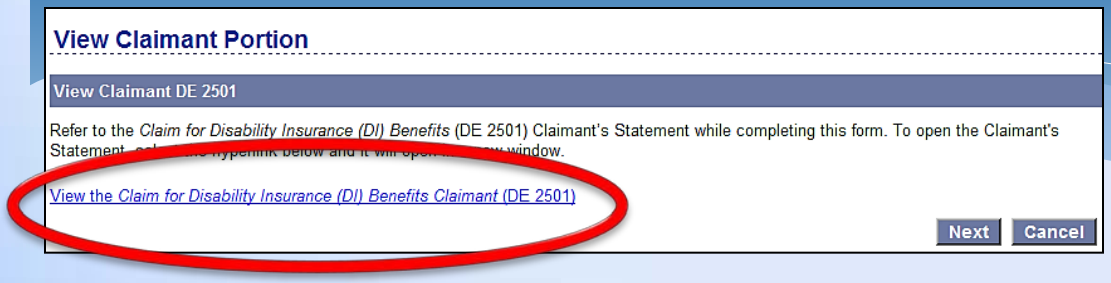

MAIN MENU
Home
Inbox
Saved Drafts
Manage My Profile
Contact Us
PAGE MENU
Change Security Questions
Change Password
Change Personal Image
Manage Treatment Address
Manage Medical Representative
Physician/Practitioner Update Personal Profile Information
*Indicates Required Field
Physician/ Practitioner Information
Address updates must be submitted in writing to the Medical Board with the Department of Consumer Affairs (DCA). DCA will provide EDD with your updated address when the next license validation is done.
Licensee Name:
Add Delete Medical Representative
Medical Representative Information
You may have no more than seven (7) representatives who may access your certification information and assist in completing the forms. Please select the Add button to enter a new Medical Representative. To modify or delete a Medical Representative, select the appropriate action. You are still responsible for certifying the medical forms.
No Results Found
Add
I prefer to be notified by e-mail.
I prefer to be notified by paper mail
I do not want to receive notifications. I will be reviewing the items in my message center regularly


Add Modify Medical Representative
*Indicates Required Field
Add Representative
*First Name:
Middle Name:
(if the medical representative has no middle name, leave blank)
*Last Name:
Suffix:
(if the medical representative has no suffix, leave blank)
*Last 4 Digits of Social Security Number:
*E-mail Address:
*Re-Type E-mail Address:
*Date of Birth:
*Treatment Address:
800 Capitol Mall Sacramento CA 95814-4807
*Account Status:
Active
Save
Cancel
Back to Top | Contact EDD | Conditions of Use | Privacy Policy | Equal Opportunity Notice


Add Delete Medical Representative
Medical Representative Information
You may have no more than seven (7) representatives who may access your certification information and assist in completing the forms. Please select the Add button to enter a new Medical Representative. To modify or delete a Medical Representative, select the appropriate action. You are still responsible for certifying the medical forms.
Name
Last 4 Digits of Social Security Number
E-mail Address
Date of Birth
Treatment Address
Account Status
Action
Jane Doe
1234
email@email.com
01-01-1950
800 Capitol Mall Sacramento CA 95814-4807
Active
Modify
Delete
Add

Submit a DE 2501 Part B – Physician/Practitioner Certificate


Home
*Indicates Required Field
License Information
Licensee Name
License Number
Jane Doe
CA00000
Message Center
Inbox [New: 0 , Total: 0]
Saved Drafts [Total: 0]
Search
To submit a form, search by Claim ID. To obtain information regarding forms previously submitted, search by My Receipt Number. To locate the claimant's portion of the application for Disability Insurance, search by Claimant Receipt Number.
*Search By: Patient Receipt Number
R100000000033909
*Patient Last Name:
Doe
Search
Cancel
Search Results
Receipt Number
Patient Name
Date of Birth
Action
R100000000033909
John Doe
01-01-1950
Submit Physician/Practitioner Certificate


View Claimant Portion
View Claimant DE 2501
Refer to the Claim for Disability Insurance (DI) Benefits (DE 2501) Claimant's Statement while completing this form. To open the Claimant's
View the Claim for Disability Insurance (DI) Benefits Claimant (DE 2501)
Next
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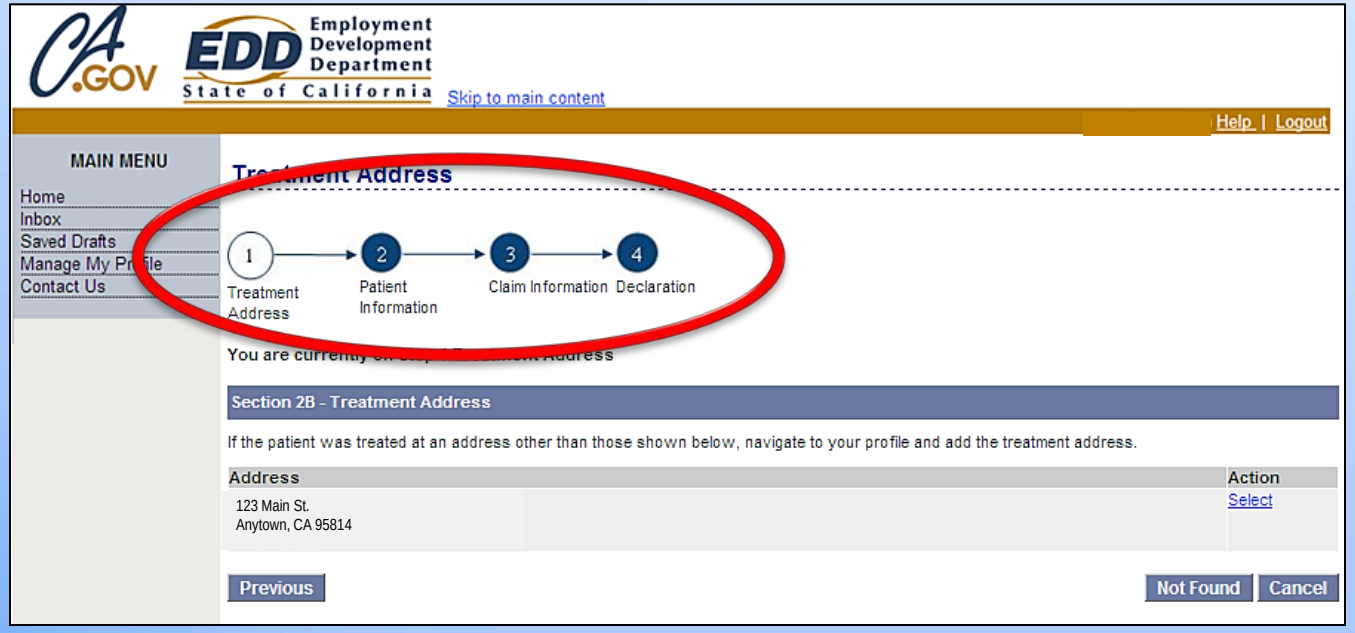
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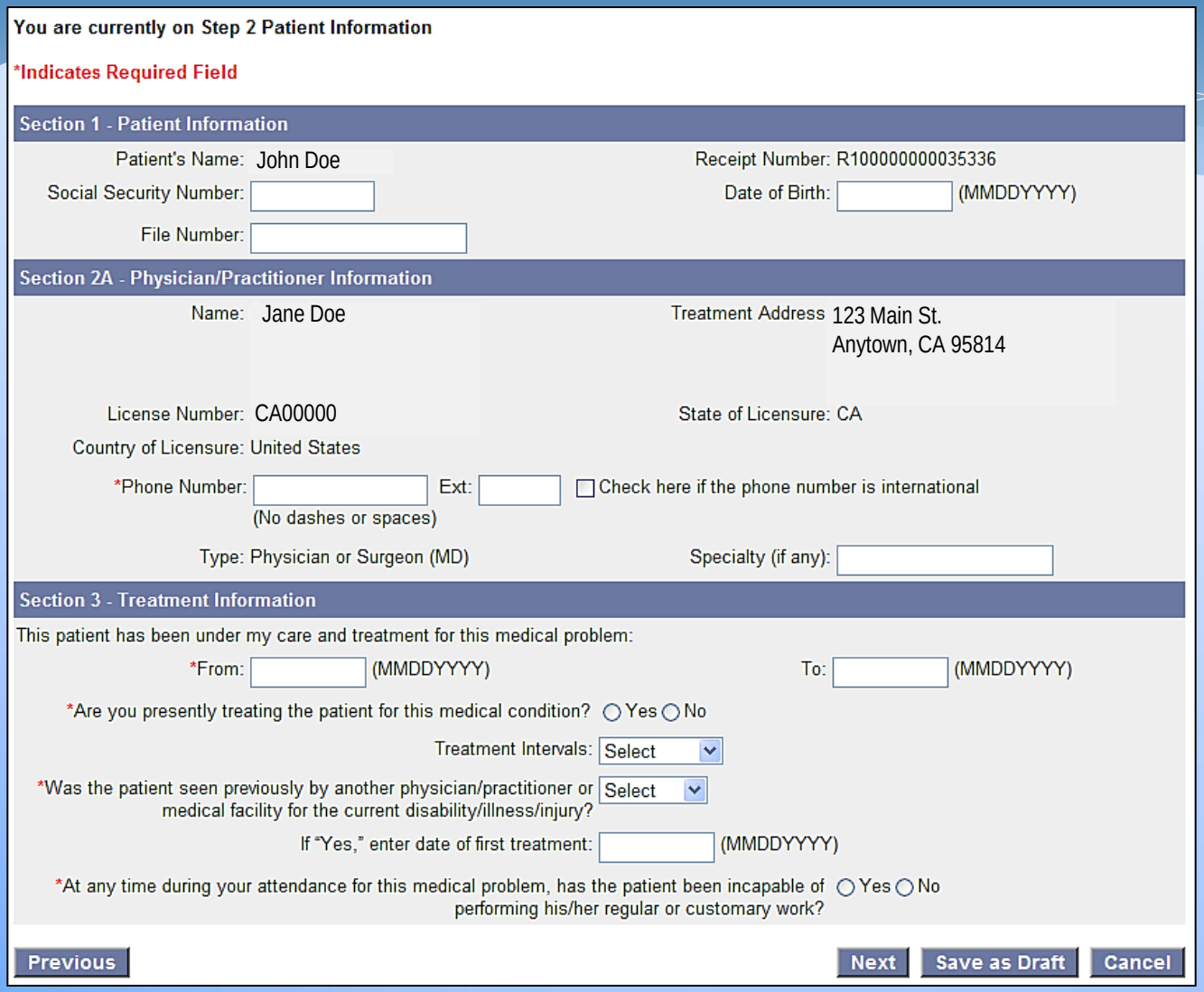
Treatment Address
1 Treatment Address
2 Patient Information
3 Claim Information
4 Declaration
You are currently on Step 1 Treatment Address
Section 2B - Treatment Address
If the patient was treated at an address other than those shown below, navigate to your profile and add the treatment address.
Address
Action
123 Main St.
Anytown, CA 95814
Select
Previous
Not Found
Cancel



You are currently on Step 2 Patient Information

*Indicates Required Field

Section 1 - Patient Information

Patient's Name: John Doe

Receipt Number: R100000000035336

Social Security Number:

Date of Birth: (MMDDYYYY)

File Number:

Section 2A - Physician/Practitioner Information

Name: Jane Doe

Treatment Address: 123 Main St.
Anytown, CA 95814

License Number: CA00000

State of Licensure: CA

Country of Licensure: United States

*Phone Number: Ext: Check here if the phone number is international

(No dashes or spaces)

Type: Physician or Surgeon (MD)

Specialty (if any):

Section 3 - Treatment Information

This patient has been under my care and treatment for this medical problem:

*From: (MMDDYYYY)

To: (MMDDYYYY)

*Are you presently treating the patient for this medical condition? Yes No

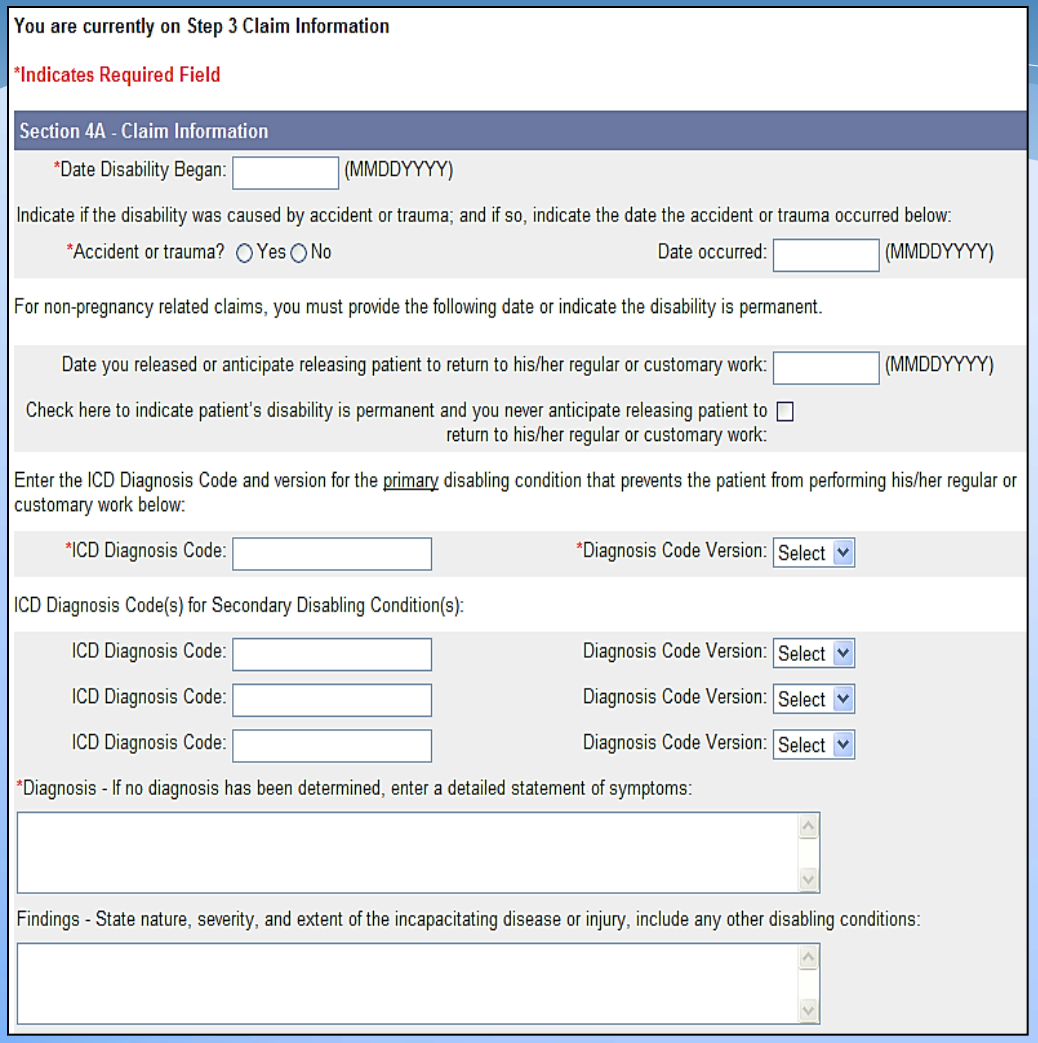
Treatment Intervals: Select

*Was the patient seen previously by another physician/practitioner or medical facility for the current disability/illness/injury? Select

If "Yes," enter date of first treatment: (MMDDYYYY)

*At any time during your attendance for this medical problem, has the patient been incapable of performing his/her regular or customary work? Yes No

Previous Next Save as Draft Cancel



You are currently on Step 3 Claim Information

*Indicates Required Field

Section 4A - Claim Information

*Date Disability Began: (MMDDYYYY)

Indicate if the disability was caused by accident or trauma; and if so, indicate the date the accident or trauma occurred below:

*Accident or trauma? Yes No Date occurred: (MMDDYYYY)

For non-pregnancy related claims, you must provide the following date or indicate the disability is permanent.

Date you released or anticipate releasing patient to return to his/her regular or customary work: (MMDDYYYY)

Check here to indicate patient's disability is permanent and you never anticipate releasing patient to return to his/her regular or customary work:

Enter the ICD Diagnosis Code and version for the primary disabling condition that prevents the patient from performing his/her regular or customary work below:

*ICD Diagnosis Code: *Diagnosis Code Version: Select

ICD Diagnosis Code(s) for Secondary Disabling Condition(s):

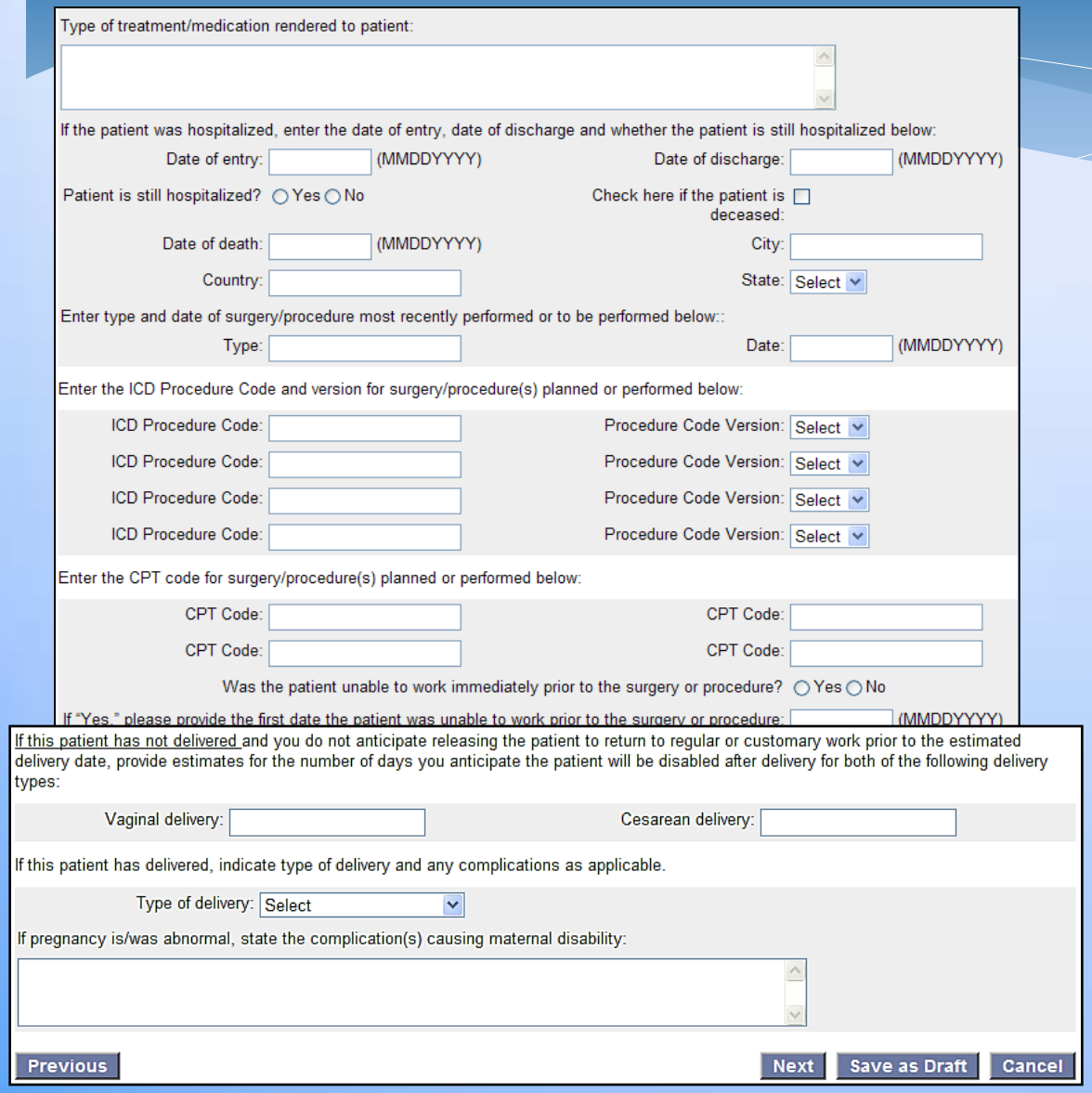
ICD Diagnosis Code: Diagnosis Code Version: Select

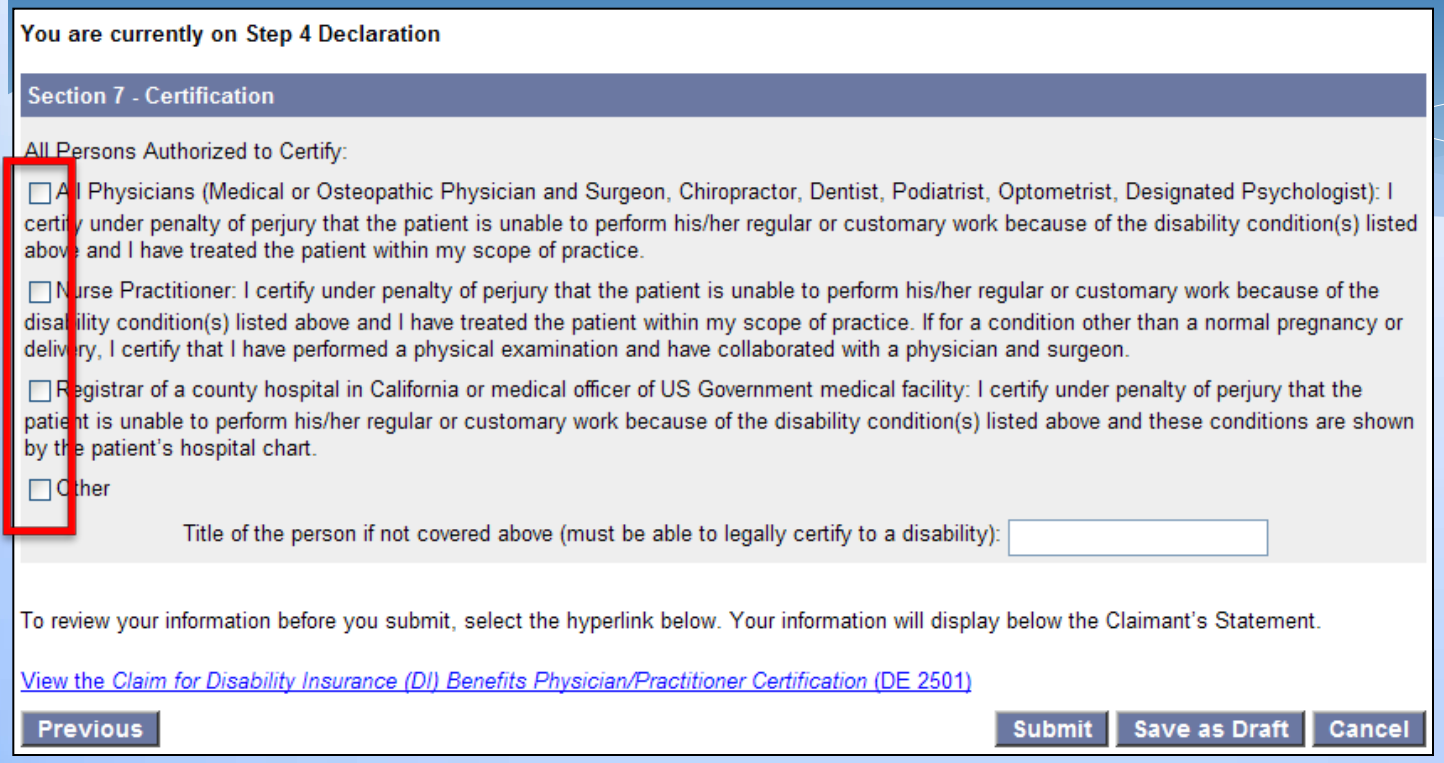
ICD Diagnosis Code: Diagnosis Code Version: Select

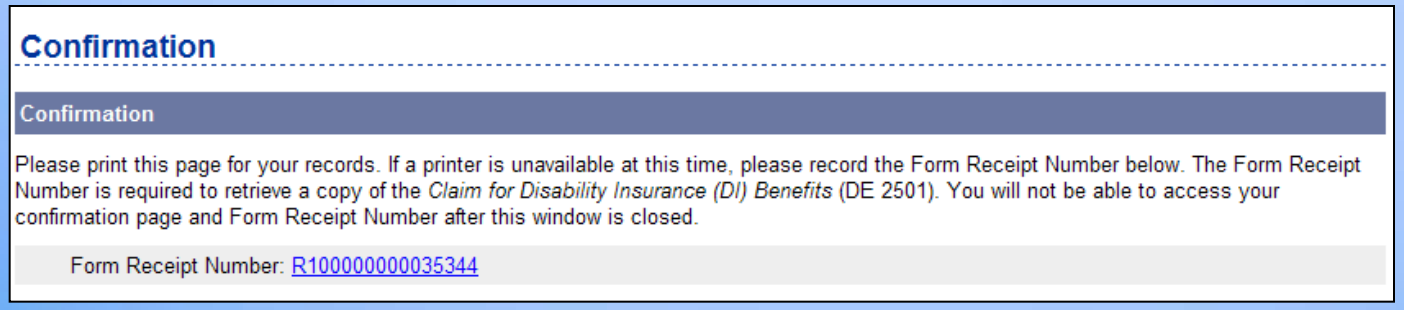
ICD Diagnosis Code: Diagnosis Code Version: Select

*Diagnosis - If no diagnosis has been determined, enter a detailed statement of symptoms:

Findings - State nature, severity, and extent of the incapacitating disease or injury, include any other disabling conditions:


Type of treatment/medication rendered to patient:
If the patient was hospitalized, enter the date of entry, date of discharge and whether the patient is still hospitalized below:
Date of entry: (MMDDYYYY)
Date of discharge: (MMDDYYYY)
Patient is still hospitalized? Yes No
Check here if the patient is deceased:
Date of death: (MMDDYYYY)
City:
Country:
State: Select
Enter type and date of surgery/procedure most recently performed or to be performed below::
Type:
Date: (MMDDYYYY)
Enter the ICD Procedure Code and version for surgery/procedure(s) planned or performed below:
ICD Procedure Code:
Procedure Code Version: Select
ICD Procedure Code:
Procedure Code Version: Select
ICD Procedure Code:
Procedure Code Version: Select
ICD Procedure Code:
Procedure Code Version: Select
Enter the CPT code for surgery/procedure(s) planned or performed below:
CPT Code:
CPT Code:
CPT Code:
CPT Code:
Was the patient unable to work immediately prior to the surgery or procedure? Yes No
If "Yes," please provide the first date the patient was unable to work prior to the surgery or procedure: (MMDDYYYY)
If this patient has not delivered and you do not anticipate releasing the patient to return to regular or customary work prior to the estimated delivery date, provide estimates for the number of days you anticipate the patient will be disabled after delivery for both of the following delivery types:
Vaginal delivery:
Cesarean delivery:
If this patient has delivered, indicate type of delivery and any complications as applicable.
Type of delivery: Select
If pregnancy is/was abnormal, state the complication(s) causing maternal disability:
Previous
Next
Save as Draft
Cancel


You are currently on Step 4 Declaration
Section 7 - Certification
All Persons Authorized to Certify:
All Physicians (Medical or Osteopathic Physician and Surgeon, Chiropractor, Dentist, Podiatrist, Optometrist, Designated Psychologist): I certify under penalty of perjury that the patient is unable to perform his/her regular or customary work because of the disability condition(s) listed above and I have treated the patient within my scope of practice.
Nurse Practitioner: I certify under penalty of perjury that the patient is unable to perform his/her regular or customary work because of the disability condition(s) listed above and I have treated the patient within my scope of practice. If for a condition other than a normal pregnancy or delivery, I certify that I have performed a physical examination and have collaborated with a physician and surgeon.
Registrar of a county hospital in California or medical officer of US Government medical facility: I certify under penalty of perjury that the patient is unable to perform his/her regular or customary work because of the disability condition(s) listed above and these conditions are shown by the patient's hospital chart.
Other
Title of the person if not covered above (must be able to legally certify to a disability):
To review your information before you submit, select the hyperlink below. Your information will display below the Claimant's Statement.
View the Claim for Disability Insurance (DI) Benefits Physician/Practitioner Certification (DE 2501)
Previous
Submit
Save as Draft
Cancel


Confirmation
Confirmation
Please print this page for your records. If a printer is unavailable at this time, please record the Form Receipt Number below. The Form Receipt Number is required to retrieve a copy of the Claim for Disability Insurance (DI) Benefits (DE 2501). You will not be able to access your confirmation page and Form Receipt Number after this window is closed.
Form Receipt Number: R100000000035344

Submit a DE 2525xx Supplementary Certificate to Continue Benefits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Home
*Indicates Required Field
License Information
Licensee Name
License Number
Jane Doe
CA00000
Message Center
Inbox [New: 0 , Total: 0]
Saved Drafts [Total: 0]
Search
To submit a form, search by Claim ID. To obtain information regarding forms previously submitted, search by My Rece
claimant's portion of the application for Disability Insurance, search by Claimant Receipt Number.
*Search By: Claim ID
DI1000000012
*Patient Last Name: Doe
Search
Cancel
Search Results
Claim ID
Patient Name
Date of Birth
Claim Effective Date
Clain
DI1000000012
John Doe
01-01-1950
03-25-2012
Disab
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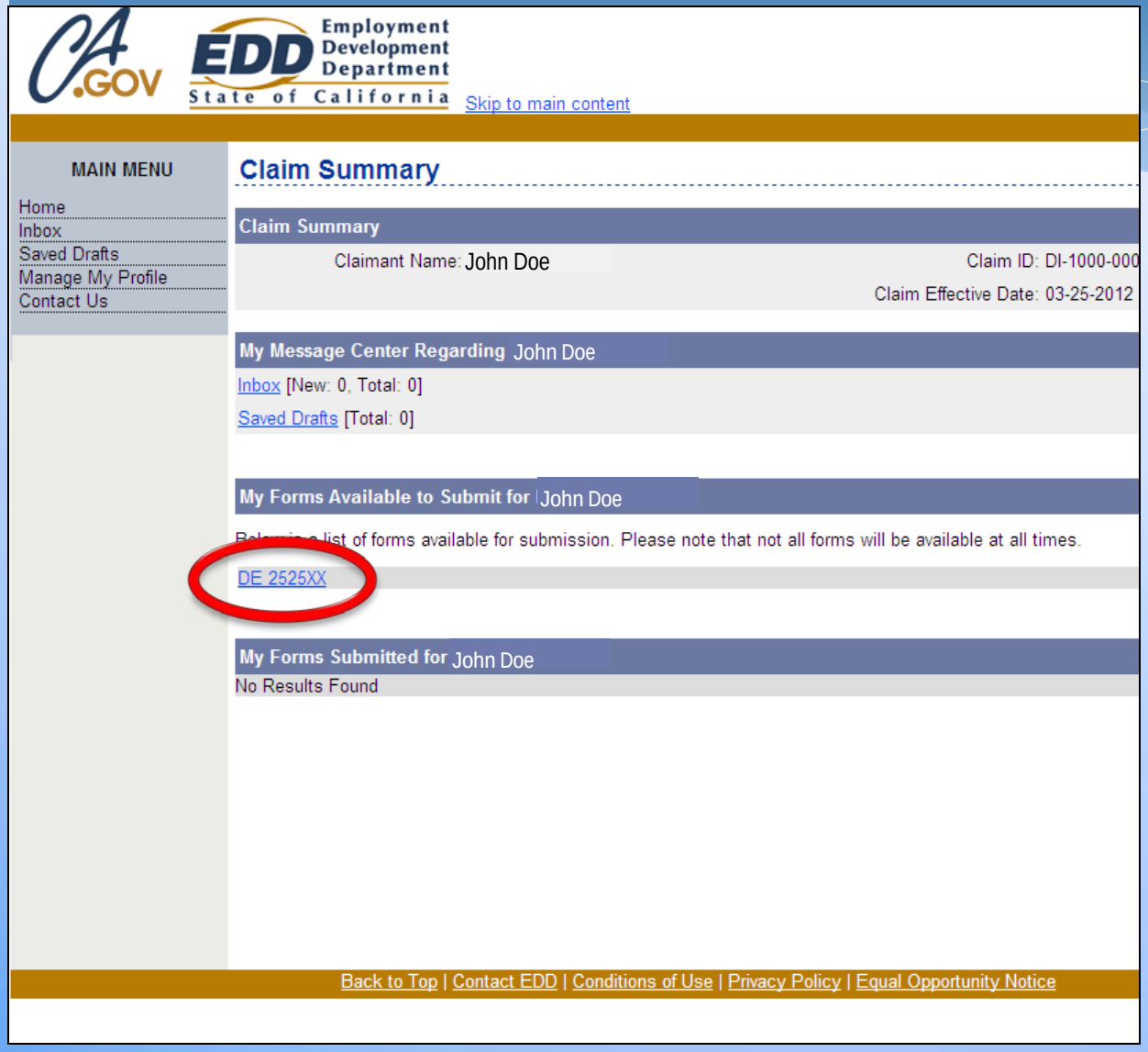
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Home
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Contact Us
Claim Summary
Claim Summary
Claimant Name: John Doe
Claim ID: DI-1000-000
Claim Effective Date: 03-25-2012
My Message Center Regarding John Doe
Inbox [New: 0, Total: 0]
Saved Drafts [Total: 0]
My Forms Available to Submit for John Doe
list of forms available for submission. Please note that not all forms will be available at all times.
DE 2525XX
My Forms Submitted for John Doe
No Results Found
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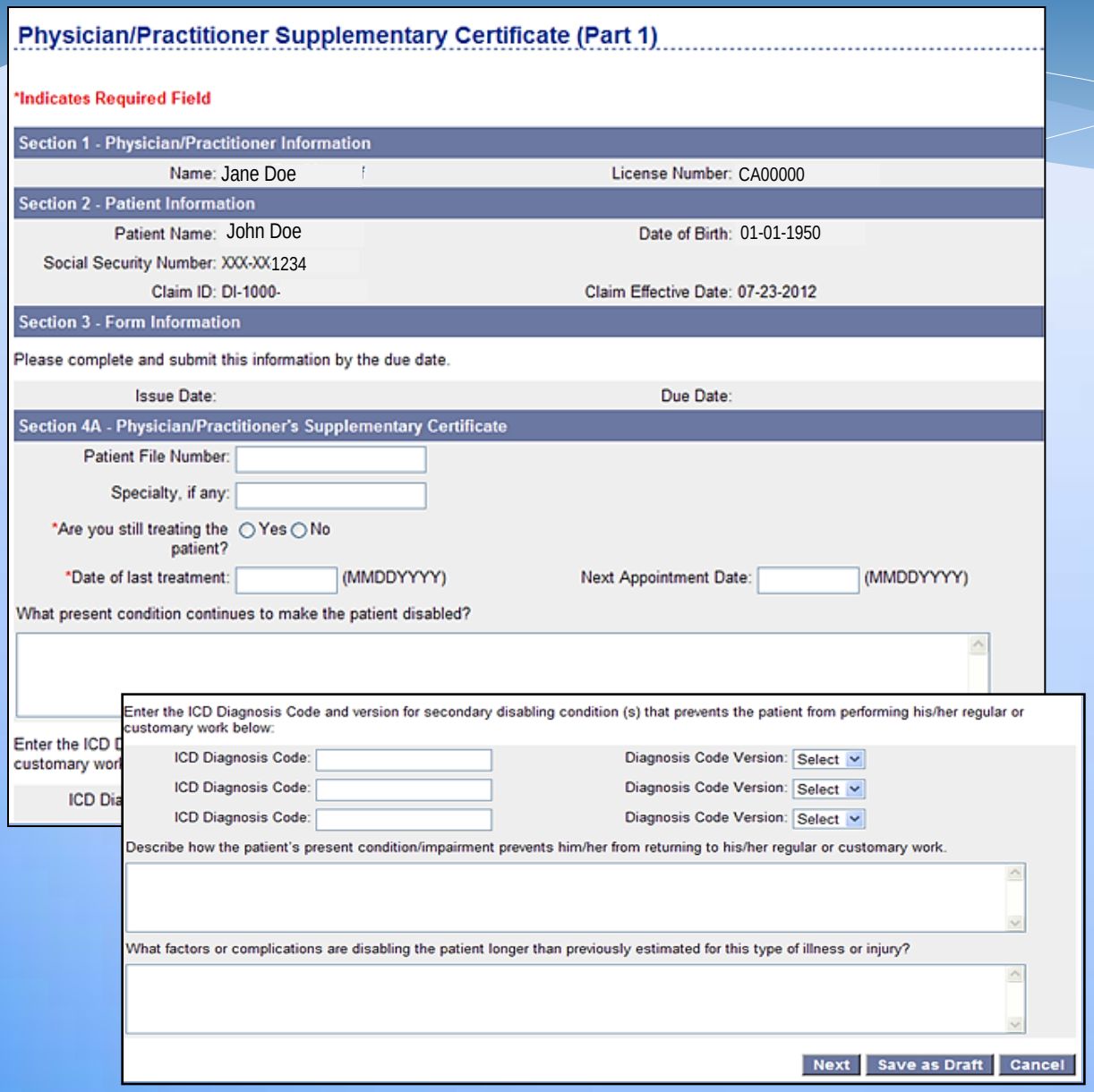

Physician/Practitioner Supplementary Certificate (Part 1)

*Indicates Required Field

Section 1 - Physician/Practitioner Information

Name: Jane Doe — License Number: CA00000

Section 2 - Patient Information

Patient Name: John Doe — Date of Birth: 01-01-1950

Social Security Number: XXX-XX1234

Claim ID: DI-1000- — Claim Effective Date: 07-23-2012

Section 3 - Form Information

Please complete and submit this information by the due date.

Issue Date: — Due Date:

Section 4A - Physician/Practitioner's Supplementary Certificate

Patient File Number:

Specialty, if any:

*Are you still treating the patient? ◯ Yes ◯ No

*Date of last treatment: (MMDDYYYY) — Next Appointment Date: (MMDDYYYY)

What present condition continues to make the patient disabled?

Enter the ICD Diagnosis Code and version for secondary disabling condition (s) that prevents the patient from performing his/her regular or customary work below:

ICD Diagnosis Code: — Diagnosis Code Version: Select

ICD Diagnosis Code: — Diagnosis Code Version: Select

ICD Diagnosis Code: — Diagnosis Code Version: Select

Describe how the patient's present condition/impairment prevents him/her from returning to his/her regular or customary work.

What factors or complications are disabling the patient longer than previously estimated for this type of illness or injury?

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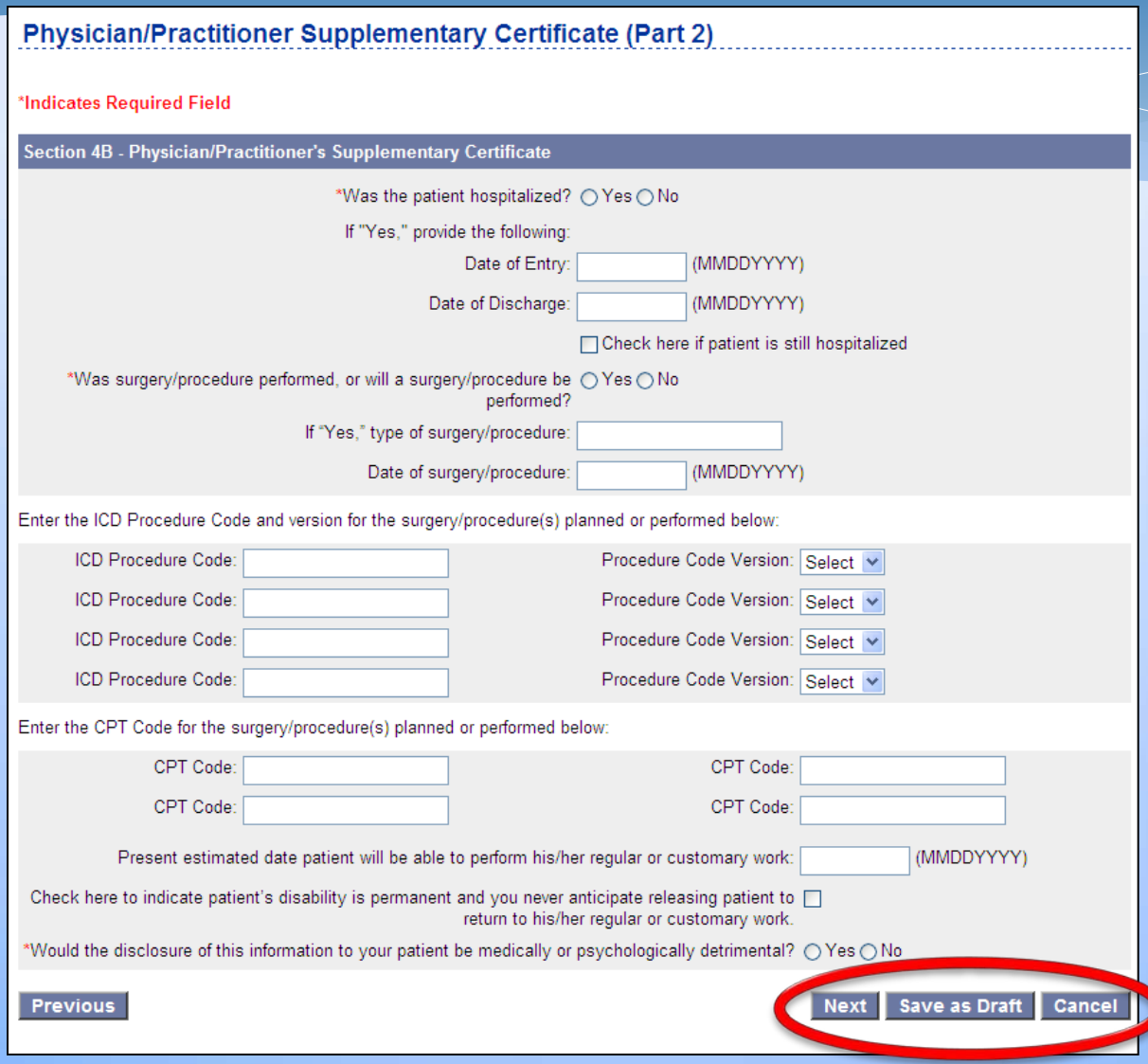
Physician/Practitioner Supplementary Certificate (Part 2)
*Indicates Required Field
Section 4B - Physician/Practitioner's Supplementary Certificate
*Was the patient hospitalized? Yes No
If "Yes," provide the following:
Date of Entry: (MMDDYYYY)
Date of Discharge: (MMDDYYYY)
Check here if patient is still hospitalized
*Was surgery/procedure performed, or will a surgery/procedure be performed? Yes No
If "Yes," type of surgery/procedure:
Date of surgery/procedure: (MMDDYYYY)
Enter the ICD Procedure Code and version for the surgery/procedure(s) planned or performed below:
ICD Procedure Code:
Procedure Code Version: Select
ICD Procedure Code:
Procedure Code Version: Select
ICD Procedure Code:
Procedure Code Version: Select
ICD Procedure Code:
Procedure Code Version: Select
Enter the CPT Code for the surgery/procedure(s) planned or performed below:
CPT Code:
CPT Code:
CPT Code:
CPT Code:
Present estimated date patient will be able to perform his/her regular or customary work: (MMDDYYYY)
Check here to indicate patient's disability is permanent and you never anticipate releasing patient to return to his/her regular or customary work.
*Would the disclosure of this information to your patient be medically or psychologically detrimental? Yes No
Previous
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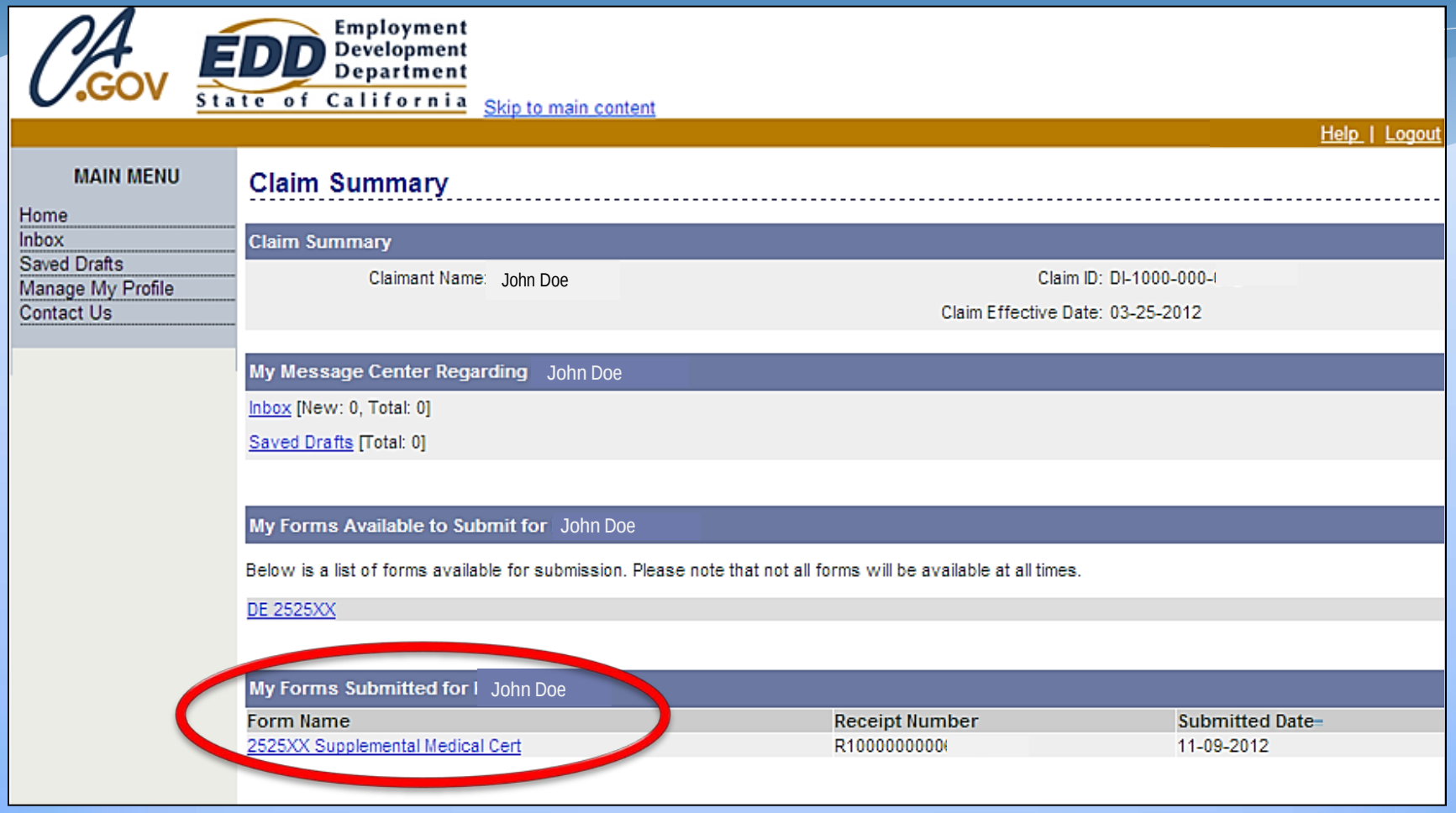
Submit Form
Section 5 - Certification
Submitted by: Jane Doe
All Physicians (Medical or Osteopathic Physician and Surgeon, Chiropractor, Dentist, Podiatrist, Optometrist, Psychologist)
I certify under penalty of perjury that the patient is unable to perform his/her regular or customary work because of the disabling condition(s) listed above and I have treated the patient within my scope of practice.
Nurse Practitioner
I certify under penalty of perjury that the patient is unable to perform his/her regular or customary work because of the disabling condition(s) listed above and I have treated the patient within my scope of practice. If for a condition other than a normal pregnancy or delivery, I certify that I have performed a physical examination and have collaborated with a physician and surgeon.
Registrar of a County Hospital in California or Medical Officer of a US Government Medical Facility
I certify under penalty of perjury that the patient is unable to perform his/her regular or customary work because of the disabling condition(s) listed above and these conditions are shown by the patient's hospital chart.
Other
Title of person if not covered above (must be able to legally certify to a disability):
Previous
Submit
Save as Draft
Cancel


Confirmation
Form Successfully Submitted
Please print this page for your records. If a printer is unavailable at this time, please record the Form Receipt Number below. The Form Receipt Number is required to retrieve a copy of the Physician/Practitioner's Supplementary Certificate (DE 2525XX). You will not be able to access your confirmation page and Form Receipt Number after this window is closed.
Form Receipt Number R100000000061009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Contact Us
Claim Summary
Claim Summary
Claimant Name: John Doe
Claim ID: DI-1000-000-
Claim Effective Date: 03-25-2012
My Message Center Regarding John Doe
Inbox [New: 0, Total: 0]
Saved Drafts [Total: 0]
My Forms Available to Submit for John Doe
Below is a list of forms available for submission. Please note that not all forms will be available at all times.
DE 2525XX
My Forms Submitted for I John Doe
Form Name
Receipt Number
Submitted Date
2525XX Supplemental Medical Cert
R1000000000
11-09-2012

Summary

* SDI Basics
* Legal Basis
* IME definition and logistics
* IME Provider Applications and Agreements
* SDI Online
  * Sign up
  * Use

SDI Contact Information

Disability Insurance English 800-480-3287	Disability Insurance Español 866-658-8846
Paid Family Leave English 877-238-4373	Paid Family Leave Español 877-379-3819

Questions?