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)**

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

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
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

**Snell**

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.

*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.

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 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.

- **Address Line 1:**
- **Address Line 2:**
- **City:**
- **State:** CA
- **ZIP Code:**
- **Phone Number:**
- **Extension:**
- **Check here if the phone number is international:**

(No dashes or spaces)
**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]
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
Access SDI Online Accounts
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: [Redacted] (case sensitive)

Log In

Forgot your personal image?
Incorrect personal image showing?
Forgot password?
<table>
<thead>
<tr>
<th>License Information</th>
<th>Licensee Name</th>
<th>License Number</th>
</tr>
</thead>
</table>

**Message Center**

- Items Requiring Attention and Notices [New: 1, Total: 3]
- Saved Drafts [Total: 7]

**Claimant/Claim Search**

- Search By: Claim ID, Claim ID, Claimant Receipt Number, My Receipt Number

**Claimant/Claim Results**
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/DisabilityFAQs.htm](http://www.edd.ca.gov/DisabilityFAQs.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
*Indicates Required Field

### License Information

<table>
<thead>
<tr>
<th>Licensee Name</th>
<th>License Number</th>
</tr>
</thead>
</table>

### 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 obtain claimant’s portion of the application for Disability Insurance, search by Claimant Receipt Number.
## 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.

<table>
<thead>
<tr>
<th>Address</th>
<th>Phone Number</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>123 Main St.</td>
<td>000-000-0000</td>
<td>[Modify Delete]</td>
</tr>
<tr>
<td>Anytown, CA 95814</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Add
Assign a Medical Representative
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 button]

Preferred Communication:
- [ ] I prefer to be notified by e-mail.
- [ ] I prefer to be notified by paper mail
- [x] I do not want to receive notifications. I will be reviewing the data in my message center regularly.
## Add 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:** [Select date] *(MM/DD/YYYY)*
  
- **Treatment Address:** 800 Capitol Mall Sacramento CA 95814-4807
  
- **Account Status:** [Active]

### Buttons

- **Save**
- **Cancel**
## 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.

<table>
<thead>
<tr>
<th>Name</th>
<th>Last 4 Digits of Social Security Number</th>
<th>E-mail Address</th>
<th>Date of Birth</th>
<th>Treatment Address</th>
<th>Account Status</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane Doe</td>
<td>1234</td>
<td><a href="mailto:email@email.com">email@email.com</a></td>
<td>01-01-1950</td>
<td>800 Capitol Mall Sacramento CA 95814-4807</td>
<td>Active</td>
<td>Modify Delete</td>
</tr>
</tbody>
</table>
Submit a DE 2501 Part B – Physician/Practitioner Certificate
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 [ ] R1000000000033909
*Patient Last Name: Doe

Search Results

<table>
<thead>
<tr>
<th>Receipt Number</th>
<th>Patient Name</th>
<th>Date of Birth</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>R1000000000033909</td>
<td>John Doe</td>
<td>01-01-1950</td>
<td>Submit Physician/Practitioner Certificate</td>
</tr>
</tbody>
</table>
### Section 1 - Patient Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's Name</td>
<td>John Doe</td>
</tr>
<tr>
<td>Social Security Number</td>
<td></td>
</tr>
<tr>
<td>Receipt Number</td>
<td>R100000000035336</td>
</tr>
<tr>
<td>Date of Birth (MMDDYYYY)</td>
<td></td>
</tr>
<tr>
<td>File Number</td>
<td></td>
</tr>
</tbody>
</table>

### Section 2A - Physician/Practitioner Information

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Jane Doe</td>
</tr>
<tr>
<td>Treatment Address</td>
<td>123 Main St.</td>
</tr>
<tr>
<td>Anytown, CA 95814</td>
<td></td>
</tr>
<tr>
<td>License Number</td>
<td>CA00000</td>
</tr>
<tr>
<td>State of Licensure</td>
<td>CA</td>
</tr>
<tr>
<td>Country of Licensure</td>
<td>United States</td>
</tr>
<tr>
<td>Phone Number</td>
<td></td>
</tr>
<tr>
<td>Ext</td>
<td></td>
</tr>
<tr>
<td>Check here if the phone number is international</td>
<td>☐</td>
</tr>
<tr>
<td>No dashes or spaces</td>
<td></td>
</tr>
<tr>
<td>Type</td>
<td>Physician or Surgeon (MD)</td>
</tr>
<tr>
<td>Specialty (if any)</td>
<td></td>
</tr>
</tbody>
</table>

### 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?  ○ Yes  ○ No

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
You are currently on Step 3 Claim Information

*Indicates Required Field

Section 4A - Claim Information

- Date Disability Began: [ ] (MM/DD/YYYY)

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

- Accident or trauma? [ ] Yes [ ] No

- Date occurred: [ ] (MM/DD/YYYY)

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: [ ] (MM/DD/YYYY)

- 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:

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 was abnormal, state the complication(s) causing maternal disability:

[ ]
You are currently on Step 4 Declaration

Section 7 - Certification

All Persons Authorized to Certify:

- [ ] 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 R1000000000035344
Submit a DE 2525xx Supplementary Certificate to Continue Benefits
<table>
<thead>
<tr>
<th>Claim ID</th>
<th>Patient Name</th>
<th>Date of Birth</th>
<th>Claim Effective Date</th>
<th>Claim Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>D10000000012</td>
<td>John Doe</td>
<td>01-01-1950</td>
<td>03-26-2012</td>
<td>Disability</td>
</tr>
<tr>
<td>My Message Center Regarding John Doe</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inbox</strong> [New: 0, Total: 0]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Saved Drafts</strong> [Total: 0]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My Forms Available to Submit for John Doe</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DE 2526XX</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>My Forms Submitted for John Doe</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No Results Found</strong></td>
</tr>
</tbody>
</table>
Physician/Practitioner Supplementary Certificate (Part 1)

**Indicates Required Field**

**Section 1 - Physician/Practitioner Information**

<table>
<thead>
<tr>
<th>Name</th>
<th>License Number: CA00000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane Doe</td>
<td></td>
</tr>
</tbody>
</table>

**Section 2 - Patient Information**

<table>
<thead>
<tr>
<th>Patient Name</th>
<th>Date of Birth</th>
<th>Social Security Number</th>
<th>Claim ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Doe</td>
<td>01-01-1950</td>
<td>XXX-XX-1234</td>
<td>DI-1000-</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Claim Effective Date</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>07-23-2012</td>
<td></td>
</tr>
</tbody>
</table>

**Section 3 - Form Information**

Please complete and submit this information by the due date.

<table>
<thead>
<tr>
<th>Issue Date</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Section 4A - Physician/Practitioner’s Supplementary Certificate**

<table>
<thead>
<tr>
<th>Patient File Number</th>
<th>Specialty, if any:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>*Are you still treating the patient? ○ Yes ○ No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>*Date of last treatment: (MMDDYYYY)</th>
<th>Next Appointment Date: (MMDDYYYY)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

What present condition continues to make the patient disabled?

<p>| |</p>
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>ICD Diagnosis Code</th>
<th>Diagnosis Code Version</th>
<th>Select</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ICD Diagnosis Code</th>
<th>Diagnosis Code Version</th>
<th>Select</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

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

<p>| |</p>
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</table>

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

<p>| |</p>
<table>
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</tbody>
</table>

Next [Save as Draft] Cancel
Submit Form

Section 5 - Certification

Submitted by Jane Doe

- [ ] All Physicians (Medical or Osteopathic Physician and Surgeon, Chiropractor, Dental, Podiatric, Optometrist, Psychologists)
- [ ] Nurse Practitioner
- [ ] Registered as a County Hospital in California or Medical Director of a U.S. Government Medical Facility
- [ ] Other

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 that I have treated the patient within my scope of practice.

Title of person if not covered above (must be able to legally certify a disability):

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 310000000081009
### Claim Summary

**Claimant Name:** John Doe  
**Claim ID:** DI-1000-000-1  
**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 John Doe

<table>
<thead>
<tr>
<th>Form Name</th>
<th>Receipt Number</th>
<th>Submitted Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>2525XX Supplemental Medical Cert</td>
<td>R10000000001</td>
<td>11-09-2012</td>
</tr>
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Summary

* SDI Basics
* Legal Basis
* IME definition and logistics
* IME Provider Applications and Agreements
* SDI Online
  * Sign up
  * Use
<table>
<thead>
<tr>
<th>Service</th>
<th>English</th>
<th>Español</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disability Insurance</td>
<td>800-480-3287</td>
<td>866-658-8846</td>
</tr>
<tr>
<td>Paid Family Leave</td>
<td>877-238-4373</td>
<td>877-379-3819</td>
</tr>
</tbody>
</table>
Questions?