Preferred Health Plan
of the Carolinas

To continue to receive STD payments, this form must be completed and returned to PHP of the Carolinas.

CONTINUED GROUP SHORT TERM DISABILITY NOTIFICATION

(to be completed by attending physician)
(Return form to: Preferred Health Plan of the Carolinas Attn: STD Processing, P. O. Box 220397, Charlotte, NC 28222

PATIENT:
_____SSN:_____

INITIAL DATE OF INJURY/ILLNESS: _____

DESCRIPTION OF INJURY/ILLNESS: _____

Patient is still under my care:	YES_____	NO_____
Patient is still totally disabled	YES_____	NO_____
Patient is still partially disabled	YES_____	NO_____
Patient is working	YES_____	NO_____
Patient will be able to return to work	**YES_____**	**NO_____**

Anticipated date of return to work/discharge from care: _____

Present condition: _____

_____

Date of next appointment: _____

Any change in diagnosis? YES_____ NO _____

Treatment plan to include symptoms, clinical findings, results of diagnostic studies, diagnosis, prognosis, and the objectives, modalities, and duration of treatment. Include details of the course of ongoing and recommended treatment and the projected results. (Attach documentation if necessary)

_____
_____

_____
_____

Signature of Physician Printed Name

Preferred Health Plan
of the Carolinas

_____ _____

_____

Address Telephone Number Date

_____

City, State, Zip