Clear Form Print Form

Service member's Last Name

Service member's Social Security Number

PART B - Medical Professional's Statement - to be completed by the attending medical professional, which includes: a licensed physician, optometrist, nurse practitioner, registered nurse or physician assistant acting within the scope of his/her practice. **Fill in information about each loss being claimed by the patient. Check yes or no in each section to indicate if that particular loss is being claimed. If the member is claiming inability to perform activities of daily living, complete the ADL Questionnaire on pages 10 and 11.**

1 Patient and Injury Information

First Name MI Last Name

Date of Injury (MM DD YYYY) What loss listed below is the patient claiming?

If patient is deceased, please provide:

Date of Death (MM DD YYYY) Time of Death ☐ A.M. ☐ P. M.

Cause of Death

2 Loss of Limbs or Digits

Is this claim for loss of limbs or digits? ☐ Yes ☐ No

If yes, please indicate the following:

Right hand at or above wrist	Date of Amputation (MM DD YYYY)	Left hand at or above wrist	Date of Amputation (MM DD YYYY)
Right foot at or above ankle	Date of Amputation (MM DD YYYY)	Left foot at or above ankle	Date of Amputation (MM DD YYYY)
Right thumb at or above the metacarpophalengeal joint	Date of Amputation (MM DD YYYY)	Left thumb at or above the metacarpophalengeal joint	Date of Amputation (MM DD YYYY)
Index finger of right hand at or above the metacarpophalengeal joint	Date of Amputation (MM DD YYYY)	Index finger of left hand at or above the metacarpophalengeal joint	Date of Amputation (MM DD YYYY)

3 Loss of Vision

Is this claim for loss of vision? ☐ Yes ☐ No

If yes, please indicate the following:

Best corrected visual acuity

Date of Observation (MM DD YYYY) Right Eye Left Eye Visual Field for right eye (degrees) Visual Field for left eye (degrees)

From what date has the visual acuity recorded above existed?

Right Eye (MM DD YYYY) Left Eye (MM DD YYYY)

If patient has suffered the anatomical loss of one or both eyes, give the date this occurred:

Right Eye (MM DD YYYY) Left Eye (MM DD YYYY)

In your medical opinion is the patient's loss of vision clinically stable and unlikely to improve? ☐ Yes ☐ No

4 Loss of Speech

Is this claim for loss of speech? ☐ Yes ☐ No

If yes, please indicate the following: Date of onset (MM DD YYYY)

Can the patient speak by voice or by whisper through normal organs of speech, (esphogeal speech and/or artificial appliances are not considered normal organs of speech)? ☐ Yes ☐ No

In your medical opinion is the patient's loss of speech clinically stable and unlikely to improve? ☐ Yes ☐ No

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5 Loss of Hearing

Is this claim for loss of hearing? ☐ Yes ☐ No If yes, comments required in Block 11.

If yes, please indicate the following:

Hearing acuity - measured via pure tone audiometry by air conduction (without amplification device)

Date of observation (MM DD YYYY)

500 Hz		1000 Hz		2000 Hz		Average	
Right Ear	Left Ear	Right Ear	Left Ear	Right Ear	Left Ear	Right Ear	Left Ear
db	db	db	db	db	db	db	db

From what date has the hearing acuity recorded above existed?

Right Ear (MM DD YYYY) Left Ear (MM DD YYYY)

In your medical opinion is the patient's loss of hearing clinically stable and unlikely to improve? ☐ Yes ☐ No

6 Paralysis

Is this claim for paralysis? ☐ Yes ☐ No If yes, comments required in Block 11.

If yes, please indicate the following:

Type of Paralysis:

☐ Hemiplegia ☐ Quadriplegia ☐ Paraplegia

Date of onset of paralysis (MM DD YYYY)

In your medical opinion is the patient's paralysis clinically stable and irreversible? ☐ Yes ☐ No

7 Burns

Is this claim for burns? ☐ Yes ☐ No

If yes, please indicate the following:

Does the patient have third degree or worse burns to the:

Face? ☐ No ☐ Yes - Please indicate percentage of face affected %

Body? ☐ No ☐ Yes - Please indicate percentage of body affected %

8 Coma

Is this claim for coma? ☐ Yes ☐ No

If yes, please indicate the following:

Date of onset of coma (MM DD YYYY)

Duration of coma ☐ Less than 15 Days ☐ 15-29 Days ☐ 30-59 Days ☐ 60-89 Days ☐ 90 Days or more

Please classify severity of brain injury using Glasgow Coma Score at 15 Days 30 Days 60 Days 90 Days

9 Traumatic Brain Injuries

Is this claim for traumatic brain injury? ☐ Yes ☐ No

If yes, please indicate the following:

Did the traumatic brain injury render the patient completely dependent upon another person to perform at least two activities of daily living (bathing, maintaining continence, dressing, eating, toileting, and transferring)? ☐ Yes ☐ No

If yes, please complete the ADL questionnaire at the end of Part B on pages 10 and 11 to document the inability to perform activities of daily living as a result of traumatic brain injuries.

10 Other Traumatic Injuries

Is this claim for traumatic injuries other than those listed above in items 1 through 9? ☐ Yes ☐ No

If yes, please indicate the following:

Did the patient's injuries render the patient completely dependent upon another person to perform at least two activities of daily living (bathing, maintaining continence, dressing, eating, toileting, and transferring)? ☐ Yes ☐ No

If yes, please complete the ADL questionnaire at the end of Part B on pages 10 and 11 to document the inability to perform activities of daily living as a result of traumatic brain injuries.

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PART B - Medical Professional's Statement (con't) to be completed by the attending medical professional, which includes: a licensed physician, optometrist, nurse practitioner, registered nurse or physician assistant acting within the scope of his/her practice. For all sections except the signature block, please type or print legibly.

11 Medical Professional's Comments

Use this block to provide any additional information about the patient's injuries.

12 Medical Professional's Information

Name of Attending Medical Professional (Please Print)

First Name MI Last Name

Medical Professional's Address (number and street) Suite

City State ZIP Code

Telephone Number Fax Number

E-mail Address

If civilian medical professional, please complete:

Specialty

License Number State of License

If military medical professional, please complete:

Rank Branch of Service

13 Medical Professional's Signature

☐ I have observed the patient's loss. ☐ I have not observed the patient's loss, but I have reviewed the patient's medical records.

This Medical Professional's Statement is based upon my examination of the patient and/or a review of pertinent medical evidence. I understand the patient and/or I may be asked to provide supporting documentation to validate eligibility under the law.

X

Signature

Date (MM DD YYYY)

WARNING: Any intentional false statement in this claim or willful misrepresentation relative thereto is subject to punishment by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001)

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Activities of Daily Living (ADL) Questionnaire

To the Medical Professional: If the patient's claim is for traumatic brain injury or other traumatic injuries not listed on the form, please complete this questionnaire to document the patient's inability to perform activities of daily living as a result of his/her injury. **NOTE:** Medical Professionals cannot certify in advance of loss (e.g. a future date for end date).

Please check one of the following…	And follow the appropriate instructions
☐ I have observed the patient's inability to perform daily activities.	Please complete the following questions and attach copies of medical records that support this claim.
☐ I have not observed the patient's inability to perform daily activities but I have reviewed the patient's medical records.	

Is this claim for inability to Bathe? ☐ Yes ☐ No If yes, please indicate the following

1. Is/Was the patient completely dependent upon another person including…
   a. taking a sponge bath ☐ Yes ☐ No c. taking a shower ☐ Yes ☐ No
   b. taking a tub bath ☐ Yes ☐ No
2. Is/Was the patient able to use accommodating equipment or adaptive behavior to get into and out of the tub/shower? ☐ Yes ☐ No
3. Is/Was the patient able to get into and out of a specially accomodating tub/shower? ☐ Yes ☐ No
4. Describe the specific physical limitations and how these limitations prevent the patient from performing this activity.
5. When did the patient's inability to perform this activity begin and end?
   Begin Date (MM DD YYYY) End Date (if applicable) (MM DD YYYY) Check here if inability is ongoing ☐

Is this claim for a lack of Continence? ☐ Yes ☐ No If yes, please indicate the following

1. Does/Did the patient experience any loss of…
   a. Bladder control? ☐ No ☐ Yes, please indicate_____times per ☐ day ☐ month
   b. Bowel control? ☐ No ☐ Yes, please indicate_____times per ☐ day ☐ month
2. Is/Was the patient completely dependent upon another person to...
   a. manage medical devices (e.g. catheter, colostomy bag)? ☐ Yes ☐ No
   b. change incontinence garments? ☐ Yes ☐ No
3. Describe the specific physical limitations and how these limitations prevent the patient from performing this activity.
4. When did the patient's inability to perform this activity begin and end?
   Begin Date (MM DD YYYY) End Date (if applicable) (MM DD YYYY) Check here if inability is ongoing ☐

Is this claim for inability to Dress? ☐ Yes ☐ No If yes, please indicate the following

1. Is/Was the patient completely dependent upon another person to dress/undress including…
   a. pulling shirt on or off (pull-over or button-type shirt)? ☐ Yes ☐ No c. fastening garments (buttons or zippers)? ☐ Yes ☐ No
   b. pulling pants on or off (pants, shorts or sweat pants)? ☐ Yes ☐ No d. securing equipment (braces, artificial limbs)? ☐ Yes ☐ No
2. Is/Was the patient able to use accommodating equipment or adaptive behavior to dress? ☐ Yes ☐ No
3. Describe the specific physical limitations and how these limitations prevent the patient from performing this activity.
4. When did the patient's inability to perform this activity begin and end?
   Begin Date (MM DD YYYY) End Date (if applicable) (MM DD YYYY) Check here if inability is ongoing ☐

REMINDER: Attach copies of any medical records that support this claim.

Service member's Last Name

Service member's Social Security Number

Is this claim for inability to Eat? ☐ Yes ☐ No If yes, please indicate the following

1. Is/Was the patient completely dependent upon another person to get food or liquid nourishment into his/her mouth? ☐ Yes ☐ No
2. Does/Did the patient require use of a feeding tube or TPN? ☐ Yes ☐ No
3. Is/Was the patient able to take liquid nourishment by mouth through a straw or cup? ☐ Yes ☐ No
4. Describe the specific physical limitations and how these limitations prevent the patient from performing this activity. ☐ Yes ☐ No
5. When did the patient's inability to perform this activity begin and end?

Begin Date (MM DD YYYY) End Date (if applicable) (MM DD YYYY) Check here if inability is ongoing ☐

Is this claim for inability to Toilet? ☐ Yes ☐ No If yes, please indicate the following

1. Is/Was the patient completely dependent upon another person when toileting, including…
   a. getting on and off the toilet/commode/bedpan/urinal? ☐ Yes ☐ No
   b. wiping oneself and performing associated personal hygiene? ☐ Yes ☐ No
2. Does/Did the patient require constant bedpan usage for each time he/she needed to toilet? ☐ Yes ☐ No
3. Is/Was the patient able to use accomodating equipment or adaptive behavior to toilet? ☐ Yes ☐ No
4. Describe the specific physical limitations and how these limitations prevent the patient from performing this activity.
5. When did the patient's inability to perform this activity begin and end?

Begin Date (MM DD YYYY) End Date (if applicable) (MM DD YYYY) Check here if inability is ongoing ☐

Is this claim for inability to Transfer? ☐ Yes ☐ No If yes, please indicate the following

1. Is/Was the patient completely dependent upon another person when transferring, including…
   a. getting in and out of bed (e.g. needed to be lifted by another person)? ☐ Yes ☐ No
   b. getting in and out of a chair (e.g. needed to be lifted by another person)? ☐ Yes ☐ No
2. Is/Was the patient able to use accomodating equipment such as a cane, crutches, bed rails or adaptive behavior to steady oneself while moving between a bed and a chair? ☐ Yes ☐ No
3. Describe the specific physical limitations and how these limitations prevent the patient from performing this activity.
4. When did the patient's inability to perform this activity begin and end?

Begin Date (MM DD YYYY) End Date (if applicable) (MM DD YYYY) Check here if inability is ongoing ☐

I have examined the patient and/or reviewed pertinent medical evidence. Based on this examination/review, I certify that this patient was unable to perform the activity(ies) of daily living indicated above.

Name of Attending Medical Professional (please print) Medical Professional's Signature Date Signed

WARNING: Any intentional false statement in this claim or willful misrepresentation relative thereto is subject to punishment by a fine of not more than $10,000 or imprisonment of not more than 5 years, or both. (18 U.S.C. 1001)

REMINDER: Attach copies of any medical records that support this claim.