United States of America
Railroad Retirement Board

Form Approved
OMB No. 3220-0039

# SUPPLEMENTAL HEALTH CARE PROVIDER'S STATEMENT

Social Security Number

Patient's Name

INSTRUCTIONS TO HEALTH CARE PROVIDER: ***Please complete all items and return this form*** in the enclosed envelope to the Railroad Retirement Board (RRB) ***immediately***. No additional sickness benefits can be paid to this patient until this supplemental medical form is completed and returned. This information is to be supplied without expense to the RRB. Also read the "Important Notice" on the previous page of this form.

1. Have you examined or treated the patient for illness or injury? ☐ Yes ☐ No
   If "Yes," give the date you last examined or treated the patient: _____

2. Please give:
   A. Diagnosis:
   B. Current objective finding:
   C. Complications (show any factors retarding recovery):
   D. Current response to treatment:

3. Did the patient require surgery? ☐ Yes ☐ No – Go to Item 4
   If "Yes" - A. Indicate the type of surgery: _____
   B. Date of most recent surgery: _____

4. If maternity, give estimated or actual date of delivery: _____

5. Do you believe the patient is now able to work without restriction in his/her last occupation?
   A. ☐ Yes – Give the date the patient became able to work: _____
   B. ☐ No – Give an estimated return-to-work date and explain how the medical evidence shows the patient is still disabled.
   Estimated return-to-work date (*if indefinite, give estimated date*): _____
   Explanation: _____

6. Has the patient reached maximum medical recovery? ☐ Yes ☐ No – Go to Item 7
   If "Yes" - A. Give the date the patient reached maximum recovery: _____
   B. Is the patient able to do some kind of work? ☐ Yes ☐ No

7. I certify that the information I am giving is true, complete, and correct. I understand that criminal and civil penalties may be imposed on me for false or fraudulent statements or for withholding information to cause or prevent payment of benefits by the RRB.

| Signature of HEALTH CARE PROVIDER | Degree/Title |
|---|---|
| Name of HEALTHCARE PROVIDER *(Print or Type)* | Date |
| Address *(Print or Type)* | Office Telephone Number *(Include area code)* ( ) |
| City, State, ZIP Code | National Provider Identifier |

UNITED STATES OF AMERICA
U.S. RAILROAD RETIREMENT BOARD - RUIA
POST OFFICE BOX 541186
HOUSTON, TX 77254-1186

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**IMPORTANT NOTICE**

## Paperwork Reduction Act Notice to Health Care Provider

Additional medical evidence is needed to support further claims for sickness benefits under the Railroad Unemployment Insurance Act (RUIA). This information is to be supplied without expense to the Railroad Retirement Board (RRB). Please complete the items on the next page. The RRB is authorized to collect this information under Section 12(i) of the RUIA. You are not required to furnish this information. If you do not, however, no benefits will be paid to your patient.

We estimate this form takes an average of 8 minutes to complete, including the time for reviewing the instructions, getting the needed data, and reviewing the completed form. Federal agencies may not conduct or sponsor, and respondents are not required to respond to, a collection of information unless it displays a valid OMB number. If you wish, send comments regarding the accuracy of our estimate or any other aspect of this form, including suggestions for reducing completion time, to Associate Chief Information Officer for Policy and Compliance, Railroad Retirement Board, 844 N. Rush Street, Chicago, Illinois 60611-1275.