RI Department of Labor and Training, Temporary Disability / Caregiver Insurance (TDI/TCI)

Medical Form Instructions

Prevent the Delay of Benefits

BE RESPONSIBLE FOR YOUR MEDICAL FORM

Did You Know?

The attached medical form is *required* to determine your eligibility for benefits or to obtain additional weeks of medical certification on your current claim.

It is ***your responsiblity*** to:

1. Provide the medical certification form to the appropriate treating Qualified Healthcare Provider (QHP - physician) for completion.

2. Mail or fax the ***completed form*** to:

   TDI/TCI
   PO Box 20100
   Cranston, RI, 02920-0941
   Fax: (401) 462-8466

Failure to complete ALL questions or submit all required material will delay the processing of your TDI/TCI claim.

Any false claim made or any information furnished that is false, is punishable by law.

Don't Forget!

This form ***must*** be completed by your treating QHP. It cannot be completed by you.

- ✓ Depending on how quickly required documents are received, it may take 2-4 weeks to determine eligibility on a new claim and 1-2 weeks on an existing claim.
- ✓ If more than one doctor is treating you, make copies of the form and provide it to each doctor who is certifying your inability to work.
- ✓ A prompt response will ensure that your claim is handled in a timely manner.
- ✓ If you are applying for TDI (illness/injury/surgery) it is ***required by law*** for you to have an in-office examination the week before the week of, or the week following the date of disability indicated by your QHP.
- ✓ ***Receipt of the completed form does not guarantee payment*** as it must be reviewed and approved. If additional documentation is required for certification, it will be requested directly from the QHP. This may result in additional processing time for the claim.
- ✓ You are responsible for any costs your doctor may charge for copying medical records or completing medical forms.
- ✓ **If you have questions on TDI/TCI:**
  - **Visit www.dlt.ri.gov/tdi online;**
  - **Call customer service at (401) 462-8420; or**
  - **Email DLT.TDI@dlt.ri.gov.**

This is a sample of a medical form.
A similar form will be sent to YOU for your healthcare provider.
YOU CANNOT USE THIS FORM

The actual medical release form will be mailed to you. It is YOUR responsibility to have your healthcare provider fill it out.

TDI–3 (Rev.1-20-16)

RHODE ISLAND DEPARTMENT OF LABOR AND TRAINING

TEMPORARY DISABILITY INSURANCE DIVISION

PO BOX 20100 CRANSTON, RHODE ISLAND 02920
Tel.# : 401-462-8420 **FAX # (401) 462-8466** TTY Via RI Relay 711

STATEMENT OF QUALIFIED HEALTHCARE PROVIDER (QHP)- Physician

Provide this form to the QHP that is treating you and make copies if needed for other QHP's treating you.
Mail or fax to TDI within ten working days of: ***1/20/2016*** QHP Code:____

Staff Initials:

Claimant's Name
Claimant's Address
Claimant's Address

Claimant's S.S.#:XXX-XX- DOB:
Print QHP's Name:_____
QHP's Address:
QHP's Address:_____

Please provide this form to the Qualified Healthcare Provider that is treating you to t the ons below.

If the above claimant is able to perform their regular and customary work while being treated for the curren y and he/sh oes not have a job to return to, please indicate a recovery date. He/She may be eligible for Unemployment Insuranc

1. Diagnosis (not symptoms):_____ **D10-CM Code ____ quired)**
2. Cause of illness/injury: ☐ Work related ☐ Illness ☐ Pregnancy ☐ accident ☐ Other:_____
3. If illness is work related, please indicate the name of the insuranc er beti
   _____
4. Any Complications slowing recovery:_____
5. Provide date closest to that patient was exam this ill injury: ____/____/____
6. Date of most recent examination date: ____/____/____
7. Was patient hospitalized for this illness/injury yes
   Hospital name: _____ d: ____ Date Discharged: ____/____/____
8. Did patient have surgery? ☐ yes
   If yes, what type of surgery:_____ Date of surgery: ____/____/____
9. If Pregnancy, expected delivery da /____ Actual delivery date: ____/____/____
   Type of delivery: ☐ Vaginal ☐ tion
   Any pregnancy com ations? Please c e: Pre or Post Partum ☐ or No Complications ☐
   The complicatio _____
10. Is patient able to pens or deli ? ☐ Full time work ☐ Part time work ☐ No work
11. Based on the inform pro medical opinion that, the above mentioned patient will be:

FRO CLAIM'S I TIVE DATE: PATIENT IS UNABLE TO WORK FOR:_____(WEEKS)

12. tient able to return t mary work on a full time basis? ☐ yes ☐ no
    ____/____/____
13. to less then his/her normal hour of work? ☐ yes ☐ no
    If yes, as of what nd for how many hours per day & week? Date: ___/___/___ **Hours per day:____ Hours per week:____**
    For how many w s patient able to work less than his/her normal hours?_____Weeks

Having considered s regular and customary work, I certify that, based on my examination, this medical certificate accurately describes the patient's illness/injury and th d of time (if any) the patient is unable to work. I certify under penalty of perjury the above statements are true and any false statements or fail to disclose facts, with intent to defraud the TDI program, I shall upon conviction be punished to the full extent allowed by law including fine and or imprisonment.

I further certify that I am a _____ - _____ License #:_____
(Type of Qualified Healthcare Provider (QHP)) (Specialty)

QHP's Name:_____ Phone #:_____ Fax#:_____

SAMPLE