Guardian

Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4) Instructions

The employee requesting PFL to care for a family member with a serious health condition must submit the *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)* with the *Request For Paid Family Leave (Form PFL-1)*.

Employee:

- Employee enters their name, date of birth, other last names, if any, under which they have worked, Social Security or Taxpayer Identification Number (TIN) number, mailing address, and care recipient's (patient's) name and date of birth at the top of page 1.
- Employee enters their name and date of birth, and care recipient's (patient's) name and date of birth at the top of page 2.
- Employee gives the *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)* to the health care provider.

HEALTH CARE PROVIDER CERTIFICATION FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION
(to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

The patient's health care provider must complete all applicable requested information unless noted as optional.

Patient Information / family member with serious health condition (to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

Question 2: Providing the optional ICD-10 code is recommended.

The patient's health care provider must complete the Patient Information and Health Care Provider sections of the *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)*.

Health care provider signs and dates, and then returns the form to the employee requesting PFL.

If you believe the patient is the victim of abuse or neglect caused by the employee requesting PFL, you may decline to provide this certification.

Employee:

- When you receive the completed *Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)* form from the health care provider, send the completed forms and supporting documentation to the insurance carrier.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 USC 552a).

The Workers' Compensation Board's (Board's) authority to request that employees provide personal information, including their social security number or tax identification number, is derived from the Board's administrative authority under Workers' Compensation Law section 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate records. Providing your social security number or tax identification number to the Board is voluntary. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law.

Guardian | NEW YORK STATE | Paid Family Leave

Request For Paid Family Leave
Health Care Provider Certification For Care Of Family Member With Serious Health Condition (Form PFL-4)

INSTRUCTIONS INCLUDED WITH FORM

TO BE COMPLETED BY THE EMPLOYEE

Plan #

Employee's name (first name, middle initial, last name)

Employee's date of birth (MM/DD/YYYY)

Other last names, if any, under which employee has worked

Employee's Social Security Number or TIN

Employee's mailing address

Mailing address

City, State | Zip code | Country (if not U.S.A.)

Care recipient's (patient's) name (first name, middle initial, last name)

Care recipient's (patient's) date of birth (MM/DD/YYYY)

HEALTH CARE PROVIDER CERTIFICATION FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION
(to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

Patient Information / family member with serious health condition (to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

1. **Does patient require care by the employee requesting Paid Family Leave (PFL)?**

☐ Yes ☐ No (If no, skip to "Health Care Provider Information".)

Note: For the purposes of this section, "providing care" may include necessary physical care, emotional support, visitation, assistance in treatment, transportation, arranging for a change in care, assistance with essential daily living matters, and personal attendant services.

2. **Primary ICD-10 code (optional)**

3. **Diagnosis**

4. **Date patient's condition commenced** (MM/DD/YYYY)

5. **First date care for patient is needed** (MM/DD/YYYY)

6. **Expected date patient will no longer require care** (MM/DD/YYYY)

7. **Estimated number of days per week OR days per month patient requires care** Days/week **OR** Days/month

Health Care Provider Information (to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above)

8. **Health care provider's name**

Form PFL-4 continued from prior page

Plan #

TO BE COMPLETED BY THE EMPLOYEE

Employee's name (first name, middle initial, last name)

Employee's social security # _____

Employee's date of birth (MM/DD/YYYY)

Care recipient's (patient's) name (first name, middle initial, last name)

Care recipient's (patient's) date of birth (MM/DD/YYYY)

HEALTH CARE PROVIDER CERTIFICATION FOR CARE OF FAMILY MEMBER WITH SERIOUS HEALTH CONDITION

(to be completed by the health care provider for the care recipient (patient) and returned to the employee identified above) - continued from prior page

Form PFL-4 continued from prior page

9. Type of health care provider:

- ☐ Medical Doctor (MD)
- ☐ Doctor of Osteopathy (DO)
- ☐ Doctor of Podiatric Medicine (DPM)
- ☐ Doctor of Chiropractic Medicine (DC)
- ☐ Dentist (DDS/DDM)
- ☐ Physician's Assistant (PA)
- ☐ Nurse Practitioner (NP)
- ☐ Licensed Psychologist
- ☐ Licensed Social Worker (LMSW/LCSW)
- ☐ Other (specify)

10. Health care provider's mailing address

Mailing address

City, State | Zip code | Country (if not U.S.A.)

11. Health care provider's telephone number (provide area or country code)

12. Health care provider's fax number (provide area or country code)

13. Health care provider's email address (if available)

14. State or country (if not U.S.A.) in which health care provider is licensed to practice

15. Specialty

16. Health care provider's license number

Certification and signature

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

My signature attests that the information I have provided in this form is based on my professional assessment within my licensed scope of practice.

Health care provider's signature

Date signed (MM/DD/YYYY) ☐☐ / ☐☐ / ☐☐☐☐