How to Fill Out the DE 2525XX

Physician/Practitioner's Supplementary Certificate

SDI Online Submissions –This Way is Faster and Easier!

https://edd.ca.gov/en/disability/SDI_Online/

To file a medical certification online, you need:

- A valid license from the California Department of Consumer Affairs.
- A one-time registration in https://edd.ca.gov/en/myedd/.

Out-of-state providers: Call 1-855-342-3645 before you complete your registration.

After registering in myEDD, follow these steps:

1. Log in to your https://myedd.edd.ca.gov/ account.
2. Select SDI Online.
3. Choose **Register as a Physician/Practitioner**.
4. Complete the ID.me verification.
5. Follow the instructions to finish registration.

For additional information: https://edd.ca.gov/en/disability/Basics_for_Physicians-Practitioners/

Paper Submissions

Information Required:

- Treatment status AND last treatment date (Question #1)
- Current condition or diagnosis (Question #2)
- Next appointment date (Question #3)
- ICD diagnosis code(s) (Question #4)
- Estimated return to work date (Question #10) Do not use "unknown" or "indefinite."
- Disclosure of information to patient (Question #11)

Instructions

- Write or print clearly. Use one letter or number per box and stay inside the lines.
- Leave the field blank if it does not apply.
- Use **black ink** only.
- Include only the documents that are necessary for processing. These may include:
  - The *Notice of Incomplete Disability Insurance Claim Form Returned to the Medical Provider* (Form DE 2532), or
  - A letter from the Physician/Practitioner that
    1. Explains why the DE 2525XX is being submitted late and
    2. Requests a late filing exception
  - **Other documents, like work status reports, are <u>not</u> required unless we ask for them**

Prevent Delays. Do not use the following:

- Address labels or stamps
- "Not applicable" or "N/A"
- Correction tape or liquid
- Signature stamps
- Strikeouts or strikethroughs
- NPI numbers

License number

- License numbers must have all letter(s) and numbers.
  Examples:
  County Hospitals: REG12345
  Government Facilities: VA12345

Signature and date

- Sign with your original, handwritten signature.
- Write the date in **MMDDYYYY** format.

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RETURN TO: ----->
DISABILITY INSURANCE
PO BOX 989605
WEST SACRAMENTO CA 95798-9605

Mailing Date
MM/DD/YYYY

Sherlock Holmes
221B Baker Street
London City, CA 22222

DE 2525XX FORM
Attaching extra documents to this form, like work status reports or lists of authorized signatures, may cause delays.

EDD Employment Development Department State of California
(800) 480-3287

PHYSICIAN/PRACTITIONER'S SUPPLEMENTARY CERTIFICATE

EDD Customer Account Number (EDDCAN)	CLAIM ID	SSN/ECN	CED
##########	DI-###-###-####	000-00-0000	MM/DD/YYYY

Claimant Instructions: If you are still disabled, contact your physician/practitioner immediately for completion of the Physician/Practitioner's Supplementary Certificate which must be submitted within twenty (20) days of the mailing date shown above or you may lose additional benefits.

Instrucciones al Solicitante de Beneficios: Si Ud. aun sigue incapacitado, comun quese con su Médico/Profesional (Medico) lo más pronto posible para completar el documento titulado en inglés "Physician/Practitioner Supplementary Certificate" el cual debe ser presentado dentro de un plazo de veinte (20) días de la fecha de envío indicada arriba o de lo contrario es posible que pueda perder beneficios adicionales.

Physician/Practitioner Instructions: For faster processing, the physician/practitioner may complete and submit this form online at www.edd.ca.gov. If this form is submitted online, you do not have to mail this form back to EDD. When completing this form, **PLEASE PRINT WITH BLACK INK.**

Check one box.

1. ARE YOU STILL TREATING THE PATIENT? [X] YES [ ] NO DATE OF LAST TREATMENT 12019999

MMDDYYYY format

2. WHAT CURRENT CONDITION(S) CONTINUES TO MAKE THE PATIENT DISABLED? (DIAGNOSI

TYPHOID FEVER

Write one letter, number, or symbol in each box. Leave a box blank if there's a space.

3. DATE OF NEXT APPOINTMENT 01019999 MMDDYYYY format

4. ICD DIAGNOSIS CODE(S) FOR DISABLING CONDITION THAT PREVENT THE PATIEN HER REGULAR OR CUSTOMARY WORK (REQUIRED)

ICD Diagnosis codes only. Corrections cause delays.

EXAMPLE OF HOW TO COMPLETE ICD CODES
ICD-9 320.1
ICD-10 G00.1

(Check only one box)
[ ] ICD-9
[X] ICD-10

PRIMARY A01.0
SECONDARY R50.9
SECONDARY R05.9
SECONDARY R51.9

Check one box. ICD version must match code(s).

ADDITIONAL QUESTIONS ON FOLLOWING PAGES

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Include pages 1, 2, and 3.

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5. DESCRIBE HOW THE PATIENT'S PRESENT CONDITION/IMPAIRMENT PREVENTS HIM/HER FROM RETURNING TO HIS/HER REGULAR OR CUSTOMARY WORK.

FEVER COUGH HEADACHE

Write one letter, number, or symbol in each box. Leave a box blank if there's a space.

6. WHAT FACTORS OR COMPLICATIONS ARE DISABLING THE PATIENT LONGER THAN PREVIOUSLY ESTIMATED?

Leave fields blank if no answer. Strikethroughs and "N/A" cause delays.

7. IF PATIENT WAS HOSPITALIZED, PROVIDE DATES OF ENTRY AND DISCHARGE M M D D Y Y Y Y TO M M D D Y Y Y Y

☐ CHECK HERE TO INDICATE THE PATIENT IS STILL HOSPITALIZED

8. DATE AND TYPE OF SURGERY/PROCEDURE PERFORMED OR TO BE PERFORMED

M M D D Y Y Y Y

9A. ICD PROCEDURE CODE(S) ☐ ICD-9 ☐ ICD-10

9B. CPT CODE(S) (D

Codes (ICD or CPT) for services or treatments performed only

10. CURRENT ESTIMATED DATE PATIENT (EVEN IF STILL UNDER TREATMENT) WILL BE ABLE TO PERFORM HIS/HER REGULAR OR CUSTOMARY WORK ("UNKNOWN," "INDEFINITE," ETC., NOT ACCEPTABLE)

04019999 MMDDYYYY format

☐ CHECK HERE TO INDICATE PATIENT'S DISABILITY IS PERMANENT AND YOU NEVER ANTICIPATE RELEASING PATIENT TO RETURN TO HIS/HER REGULAR OR CUSTOMARY WORK

Check one box.

11. WOULD DISCLOSURE OF THE INFORMATION ON THIS FORM BE MEDICALLY OR PSYCHOLOGICALLY DETRIMENTAL TO YOUR PATIENT? ☐ YES ☒ NO

ADDITIONAL QUESTIONS AND SIGNATURE REQUIRED ON NEXT PAGE

Include pages 1, 2, and 3.

License Number must have letter(s) and numbers.

Examples:
NP54321
DC12345
NMW1234
REG12345
VA12345

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12. PHYSICIAN/PRACTITIONER'S LICENSE NUMBER: A123456

13. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED THE LICENSE NUMBER ENTERED IN QUESTION 12: STATE CA

14. PHYSICIAN/PRACTITIONER'S NAME
(FIRST) JOHN (MI) (LAST) WATSON (SUFFIX)

15. PHYSICIAN/PRACTITIONER LICENSE TYPE: PHYSICIAN

License Type

Examples:
Nurse Practitioner (NP)
Chiropractor (DC)
Nurse Midwife (NMW)
County Facility
Veterans Administration

Write one letter, number, or symbol in each box. Leave a box blank if there's a space.

17. PHYSICIAN/PRACTITIONER'S ADDRESS
MAILING ADDRESS, PO BOX, OR NUMBER/STREET/SUITE#: 221 BAKER ST APT B
CITY: MYSTERY STATE: CA ZIP OR POSTAL CODE: 44444 COUNTRY (IF NOT U.S.A.)

18. COUNTY HOSPITAL/GOVERNMENT FACILITY ADDRESS
FACILITY NAME (IF APPLICABLE)
FACILITY ADDRESS, NUMBER/STREET/SUITE#
CITY STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)

Address(es) must meet USPS Standards.
Use the ZIP Code™ lookup tool on USPS.com

Physician/Practitioner's Certification:

I certify under penalty of perjury that the patient is unable to perform his/her regular or customary work because of the listed disabling condition(s). I have performed a physical examination and/or treated the patient. I am authorized to certify a patient disability or serious health condition pursuant to California Unemployment Insurance Code Section 2708.

Leave this red area blank.

19. PHYSICIAN/PRACTITIONER'S ORIGINAL SIGNATURE – RUBBER STAMP IS NOT ACCEPTABLE

John Watson m.d
SIGNATURE

Handwrite signature on the red line.

DATE SIGNED: 12019999 (MMDDYYYY format)
AREA CODE/PHONE NUMBER: 555 666 7777

violation for any individual who, with intent to defraud, falsely certifies the medical condition of any person in order to obtain Disability Insurance benefits, whether for the maker or for any other person, and is punishable by imprisonment and/or a fine not exceeding $20,000. Section 1143 requires additional administrative penalties.

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Include pages 1, 2, and 3.