Date: [Date]

To: [Insurance Company Name]
Attn: [Claims Adjuster Name/Case Number]
Address: [Insurance Company Address]

RE: Long Term Disability Certification for [Patient Name]
Date of Birth: [Patient DOB]
Claim Number: [Claim Number]

To Whom It May Concern,

I am the treating physician for [Patient Name], who has been under my care since [Start Date]. This letter serves as medical certification regarding the patient's ongoing disability and functional limitations.

Diagnosis and Clinical Status:
The patient is currently diagnosed with [Primary Diagnosis/ICD-10 Code]. Symptoms include [list key symptoms such as chronic pain, cognitive impairment, fatigue, etc.]. These conditions are supported by [mention objective tests: MRI, Lab Work, Clinical Exams].

Functional Limitations:
Due to the patient's medical condition, they are restricted in the following ways:

- **Physical:** [e.g., Patient cannot sit for more than 30 minutes or lift over 5 lbs.]
- **Cognitive:** [e.g., Impaired concentration and medication side effects prevent complex tasks.]
- **Schedule:** [e.g., Patient requires frequent unscheduled breaks and has multiple weekly appointments.]

Work Capacity:
Based on the aforementioned limitations, it is my professional medical opinion that [Patient Name] is unable to perform the material and substantial duties of [his/her/their] own occupation or any occupation for which they are reasonably suited by education, training, or experience. These restrictions are expected to last [Estimated Duration/Permanent].

Treatment Plan:
The patient is currently following a treatment plan consisting of [Medications, Therapy, Specialist Referrals]. Despite compliance, the patient has not reached Maximum Medical Improvement (MMI) and remains disabled from the workforce.

Please contact my office at [Phone Number] if you require additional medical records or clarification.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Medical Specialty]
[Practice Name]
[License Number]