SDI Online Tutorial:

Physician/Practitioner and Physician/Practitioner Representative Registration, Online Access Information, and Form Submission

Employment Development Department
State of California

SDI Online Overview for Physicians/Practitioners

Physicians/practitioners and their representatives may use SDI Online to:

- Complete medical certifications for Disability Insurance and Paid Family Leave benefits.
- Complete medical certifications for benefits on behalf of the physician/practitioners.
- Update contact information.
- Access electronic requests for additional medical information.

- A physician/practitioner may have an unlimited number of authorized representatives.

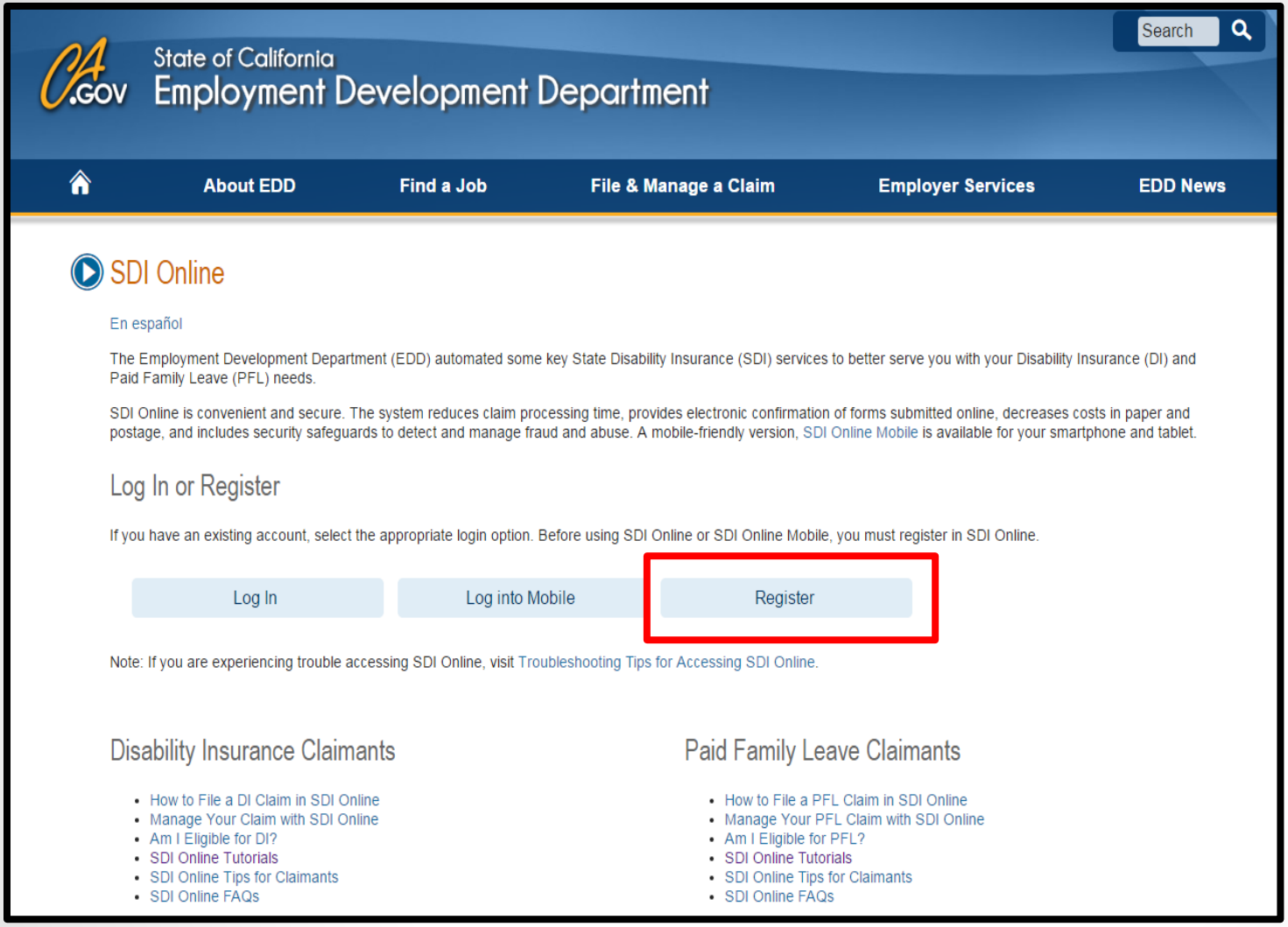
- A physician/practitioner representative may create an account after the physician/practitioner has added them as an authorized representative to their SDI Online account.

- An individual may be an authorized physician/practitioner representative for an unlimited number of physicians/practitioners.

Physician/Practitioner Registration

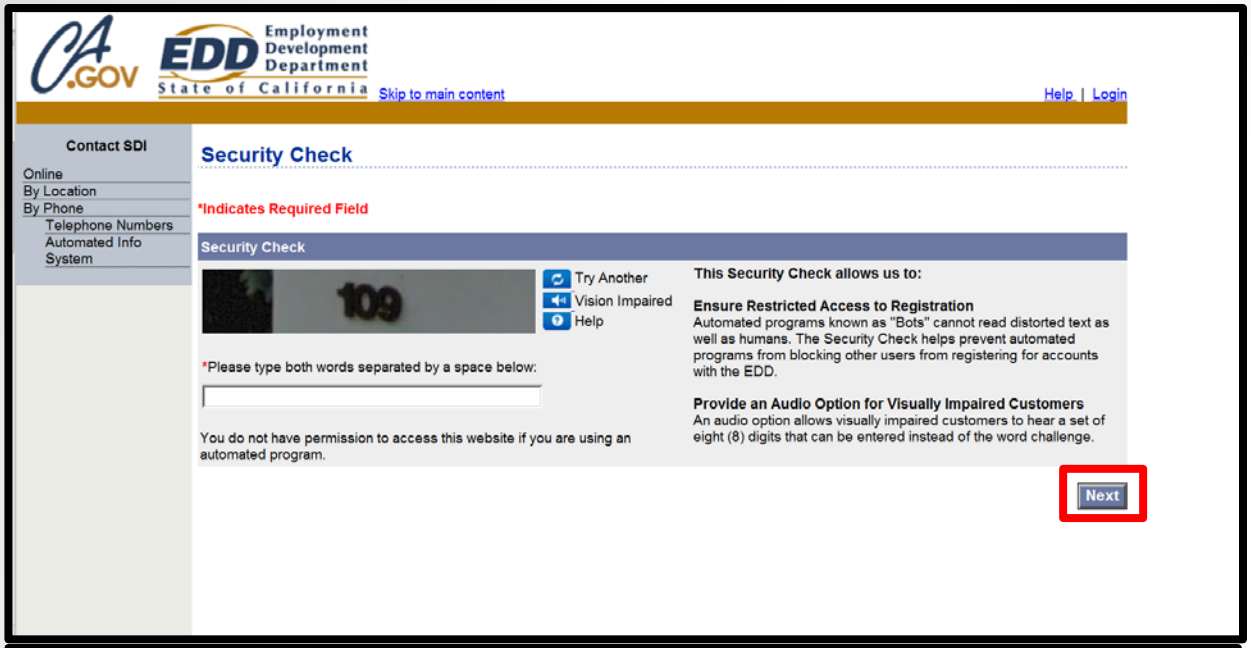
To create an SDI Online account, visit **www.edd.ca.gov/disability**.

On the **State Disability Insurance** overview page, select any **SDI Online** link.

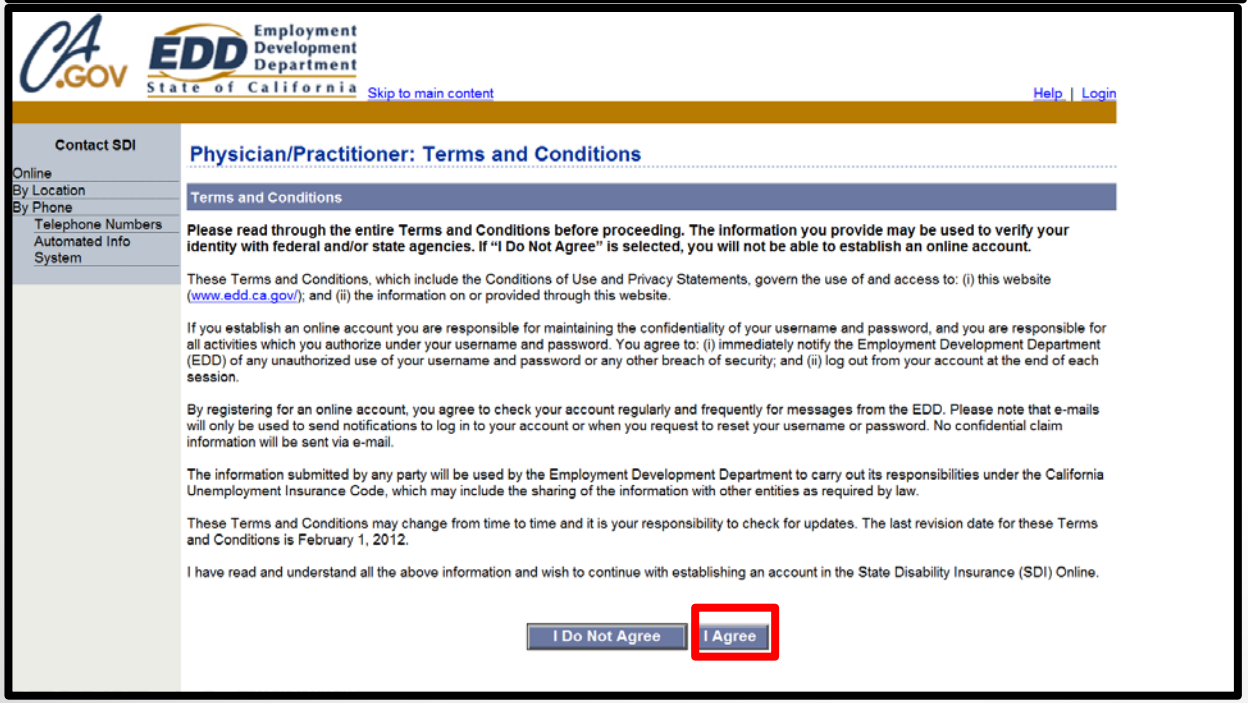


Select the **SDI Online Registration** link to register.

You will be directed to the **SDI Registration Instructions** page. Select **Continue to Physician/Practitioner Registration** and follow the instructions.

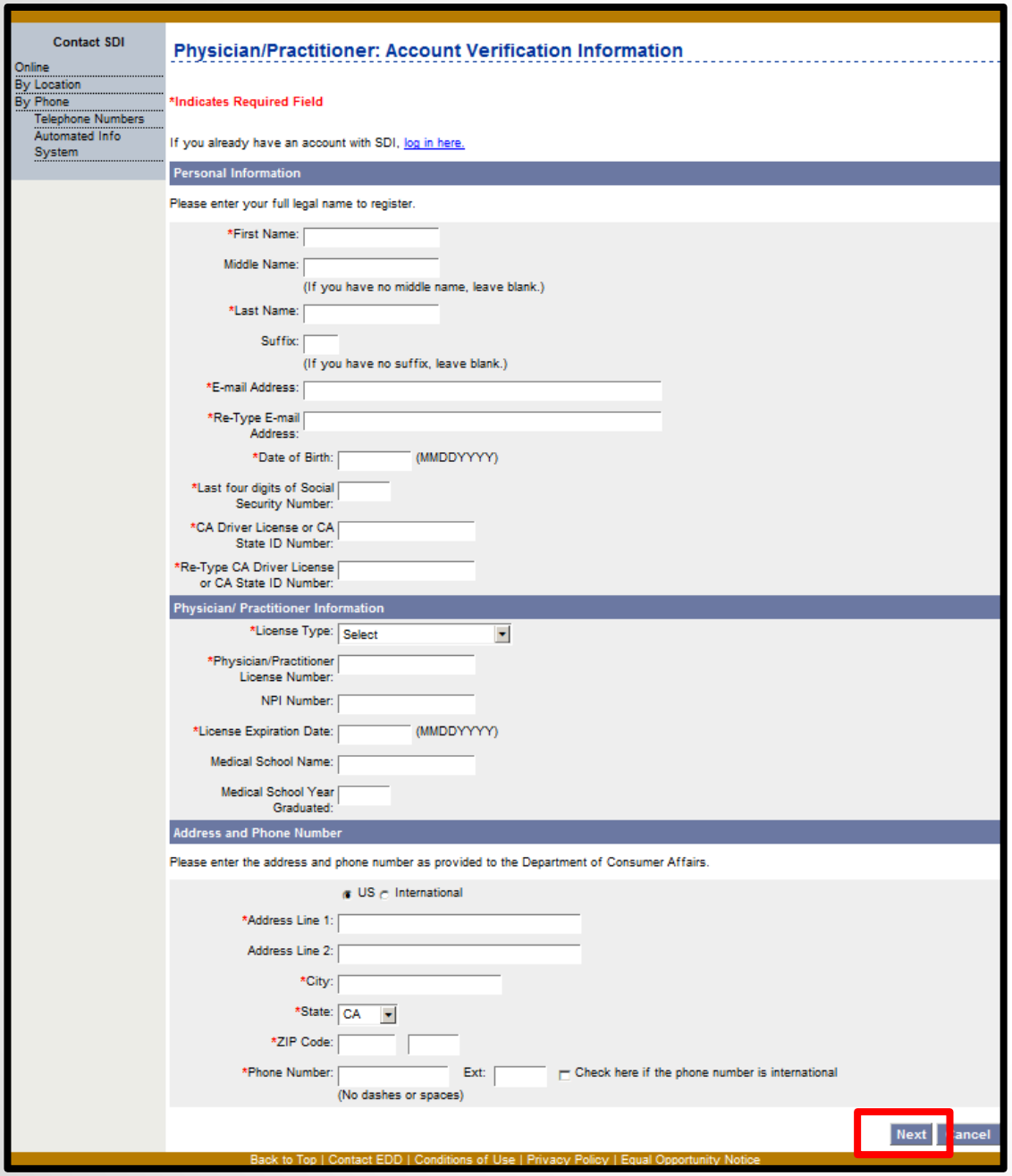


On the **Security Check** page, type the text displayed and then select **Next**.



Read the Terms and Conditions and select **I Agree**.

Selecting **I Do Not Agree** prevents an account from being established.



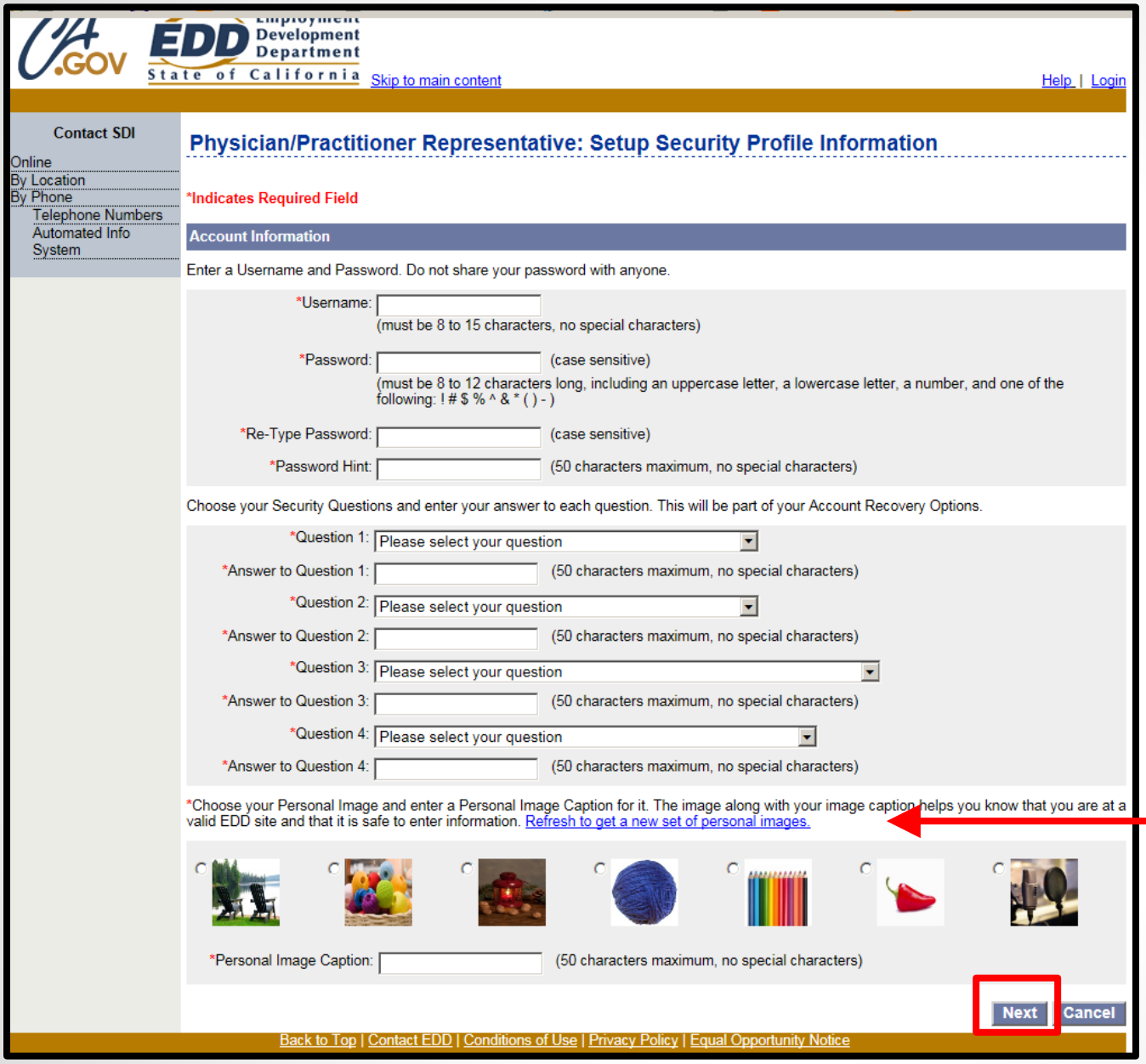
Complete the Account Verification Information and select **Next**.

Mandatory fields are marked with a red asterisk (*).

When creating an SDI Online account, remember to:

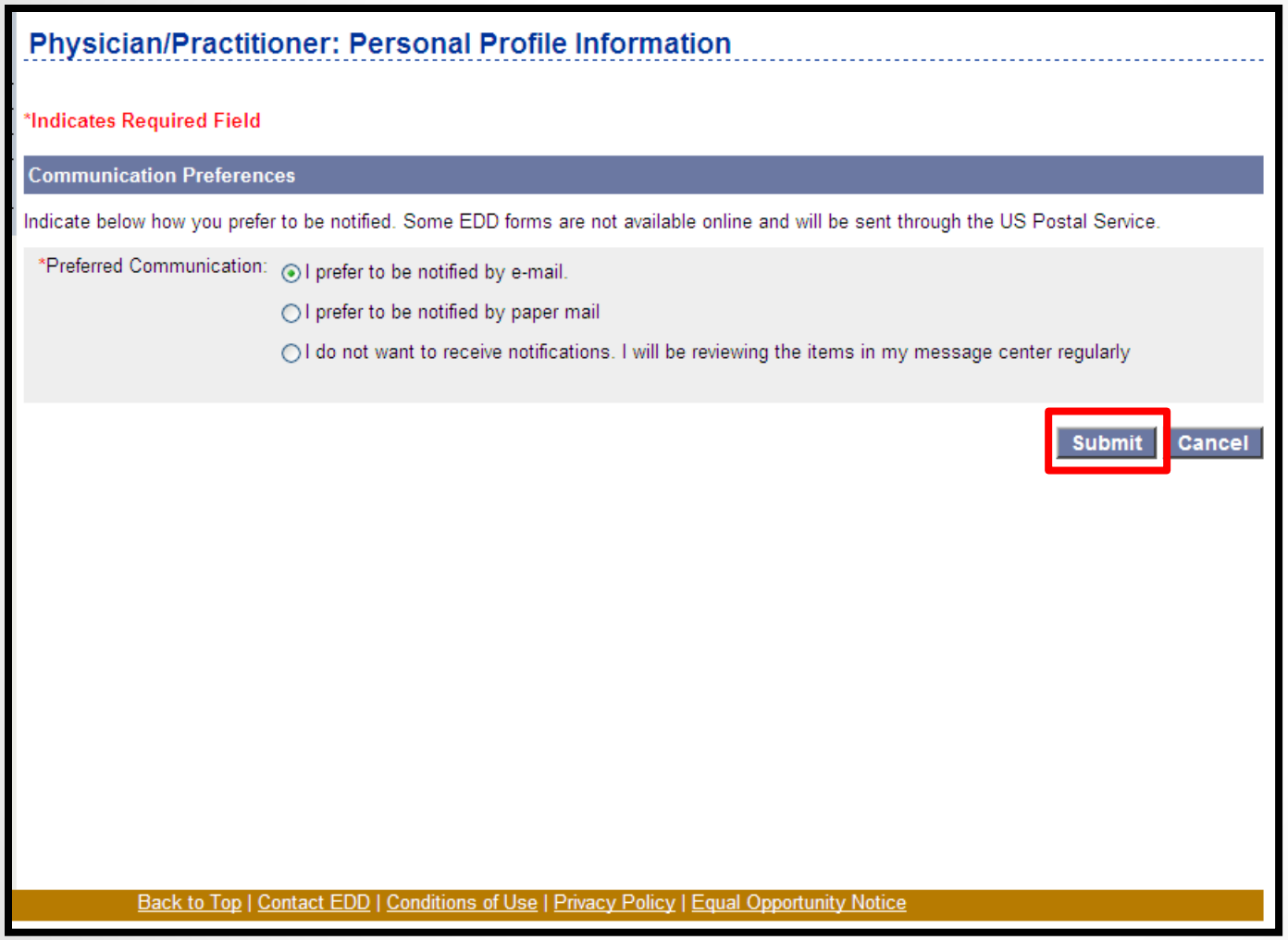
- Enter the personal medical information as it appears in the registration with your medical board.
- Enter the mailing address the medical board has on file.

Note: You will be able to add treatment addresses once the account is created.

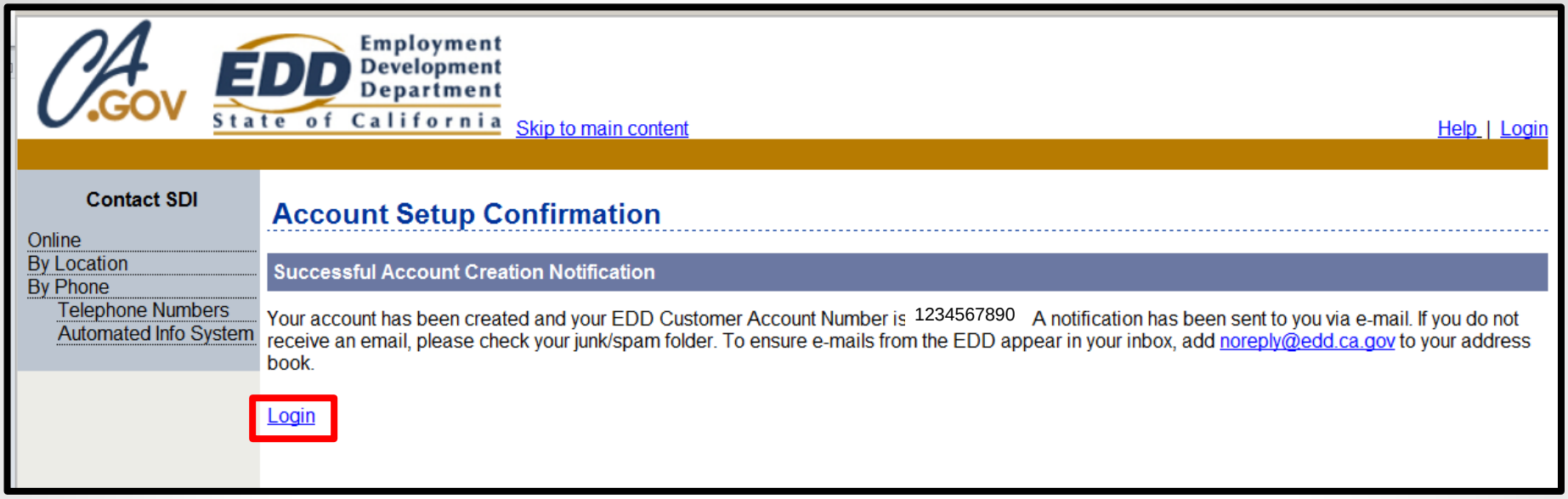


Complete the Account Information section by selecting a Username, Password, Personal Image, and Security Questions and entering your answers. Then select **Next**.

Be sure to make note of this information to ensure easy access when using SDI Online.



On the **Personal Profile Information** page, select your preferred method of communication, then select **Submit**.

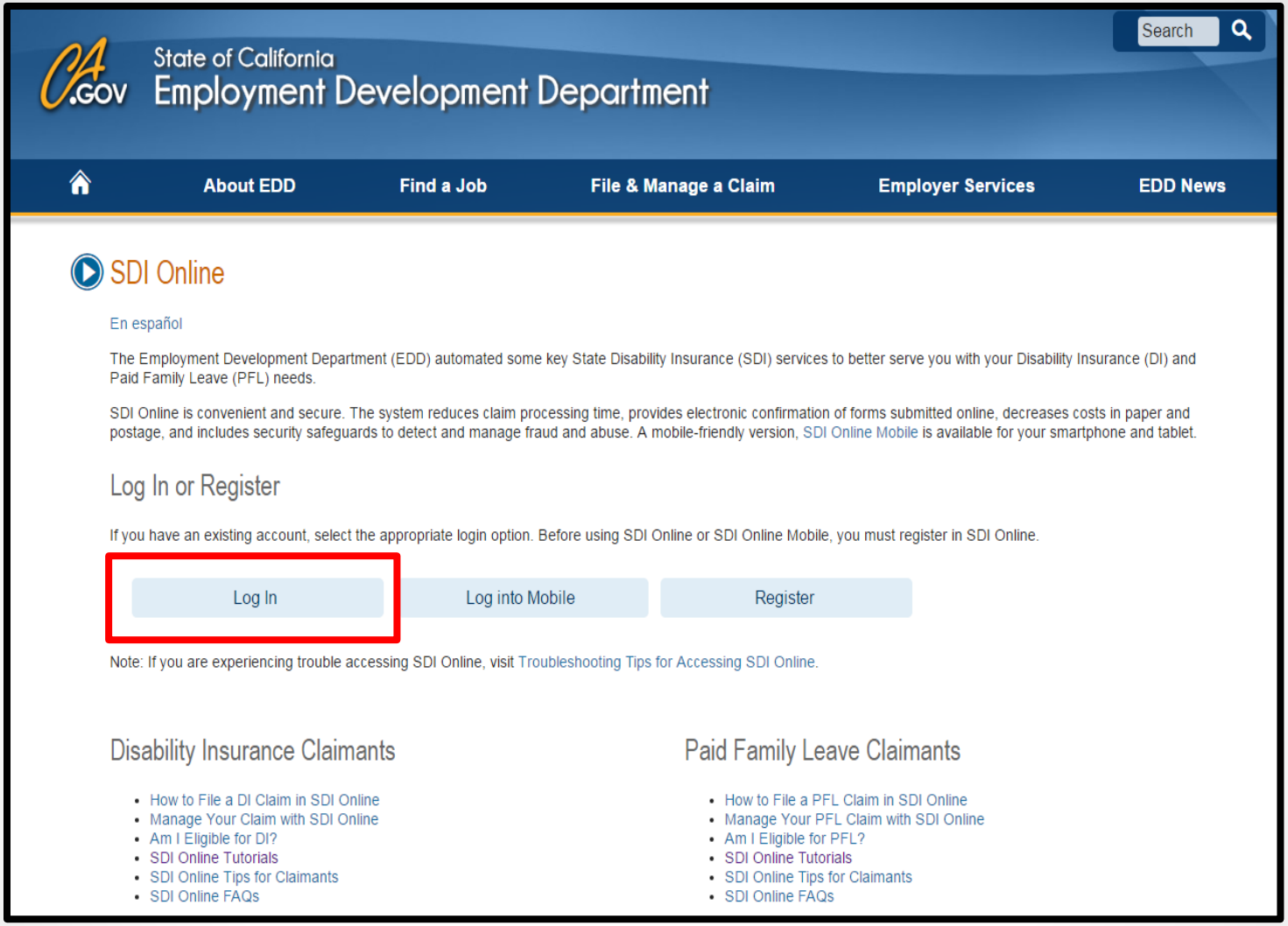


A letter will be mailed to your address to confirm this account has been created. Be sure to make a note of your EDD Customer Account Number.

If you selected electronic communication, a notification will also be sent to you via e-mail.

Select **Login** to access your newly created account.

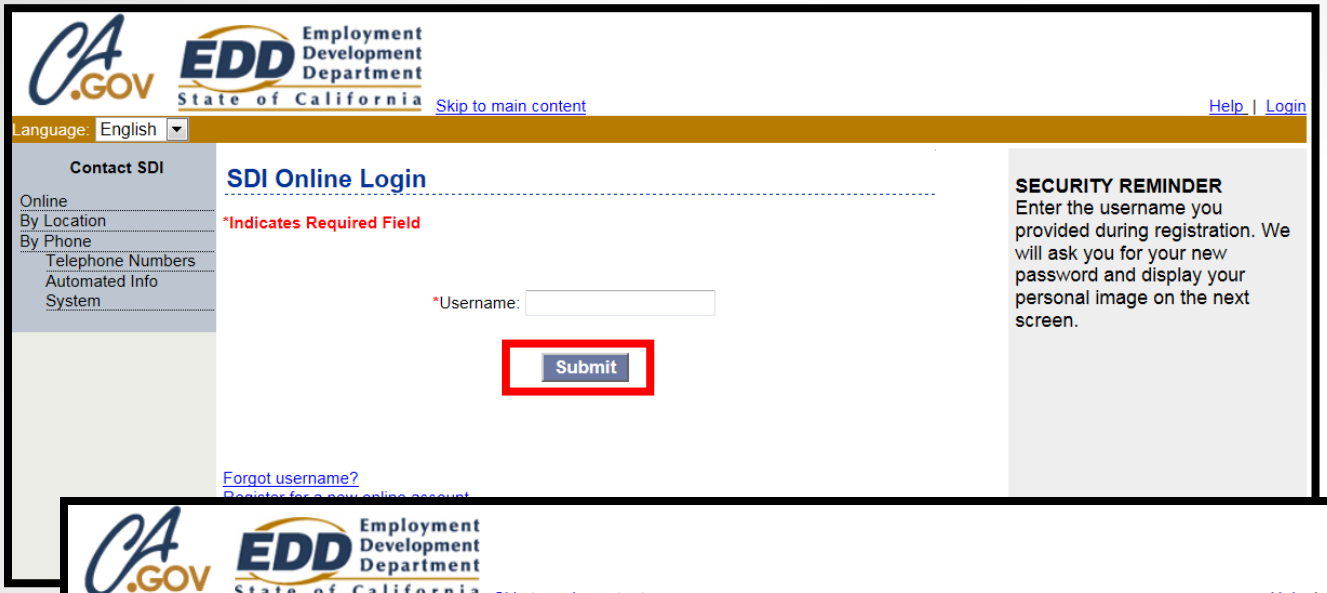
Access Physician/Practitioner Account



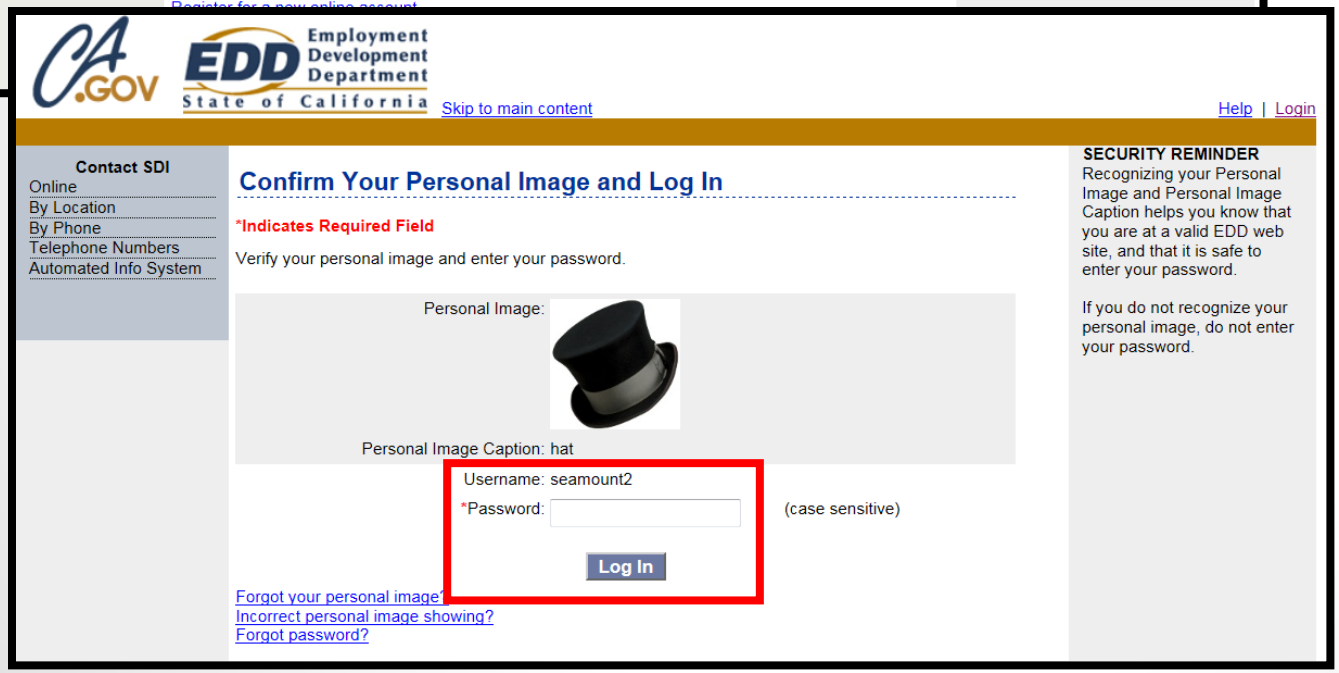
To access your account, visit **www.edd.ca.gov/disability** and select the **SDI Online** link.

On the **State Disability Insurance (SDI) Online** page, select **SDI Online Login**.

You will be directed to the **SDI Online Login** page where you will log in using your Username and Password.



On the **SDI Online Login** page, enter your Username and select **Submit**.

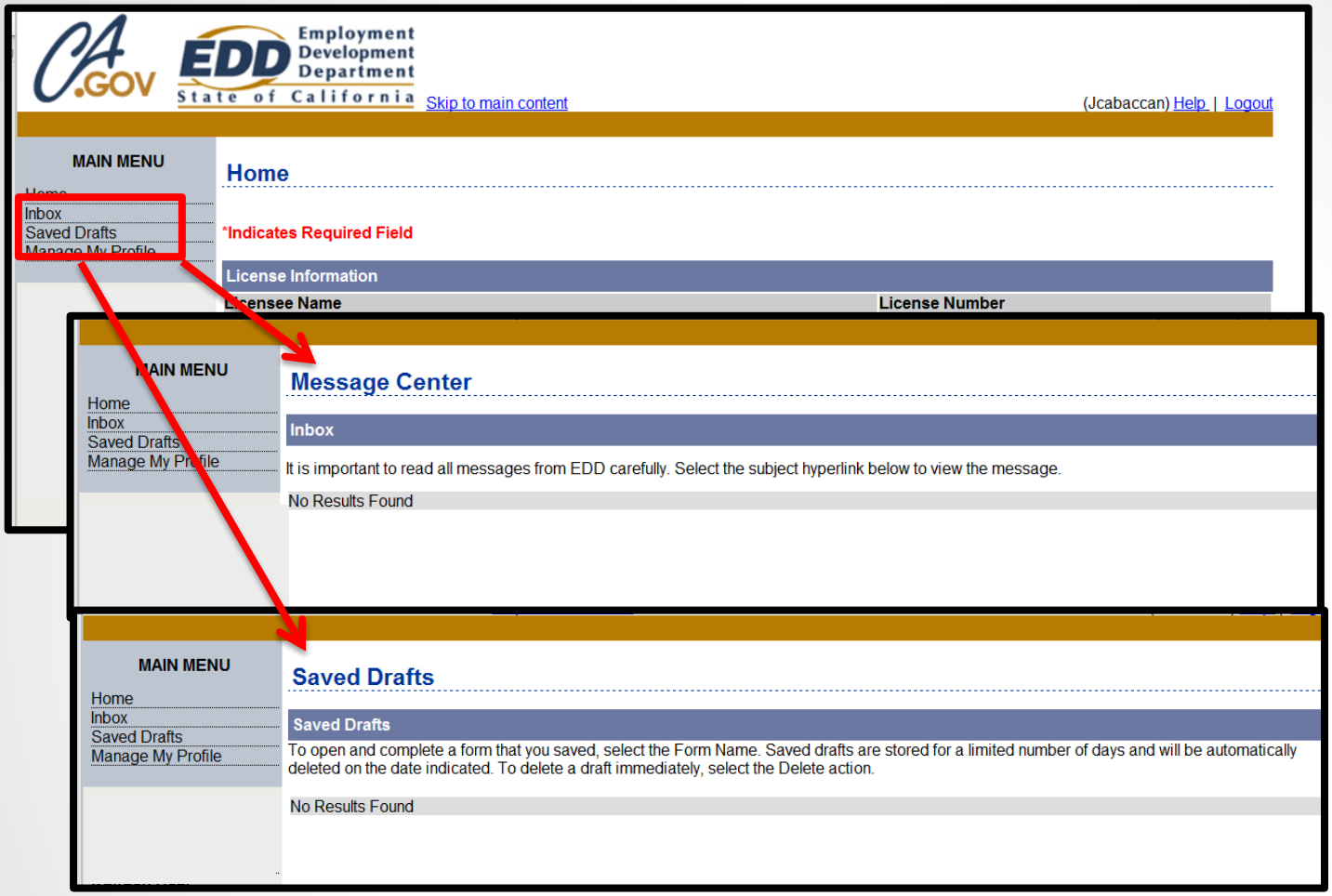


Confirm the Personal Image, enter your Password, then select **Log In**.

On the **Home** page, under the Search section, there are four ways to begin searching for certifications and forms:

- Search by "Last 4 digits of SSN" or "Patient Receipt Number" and enter the patients date of birth.
- Search by "Claim ID" to submit medical extensions.
- Search by "My Receipt Number" to view forms you have submitted.
- Search by "Patient/PFL Receipt Number" to submit Paid Family Leave forms.

You must also enter the claimant's last name to begin the search.



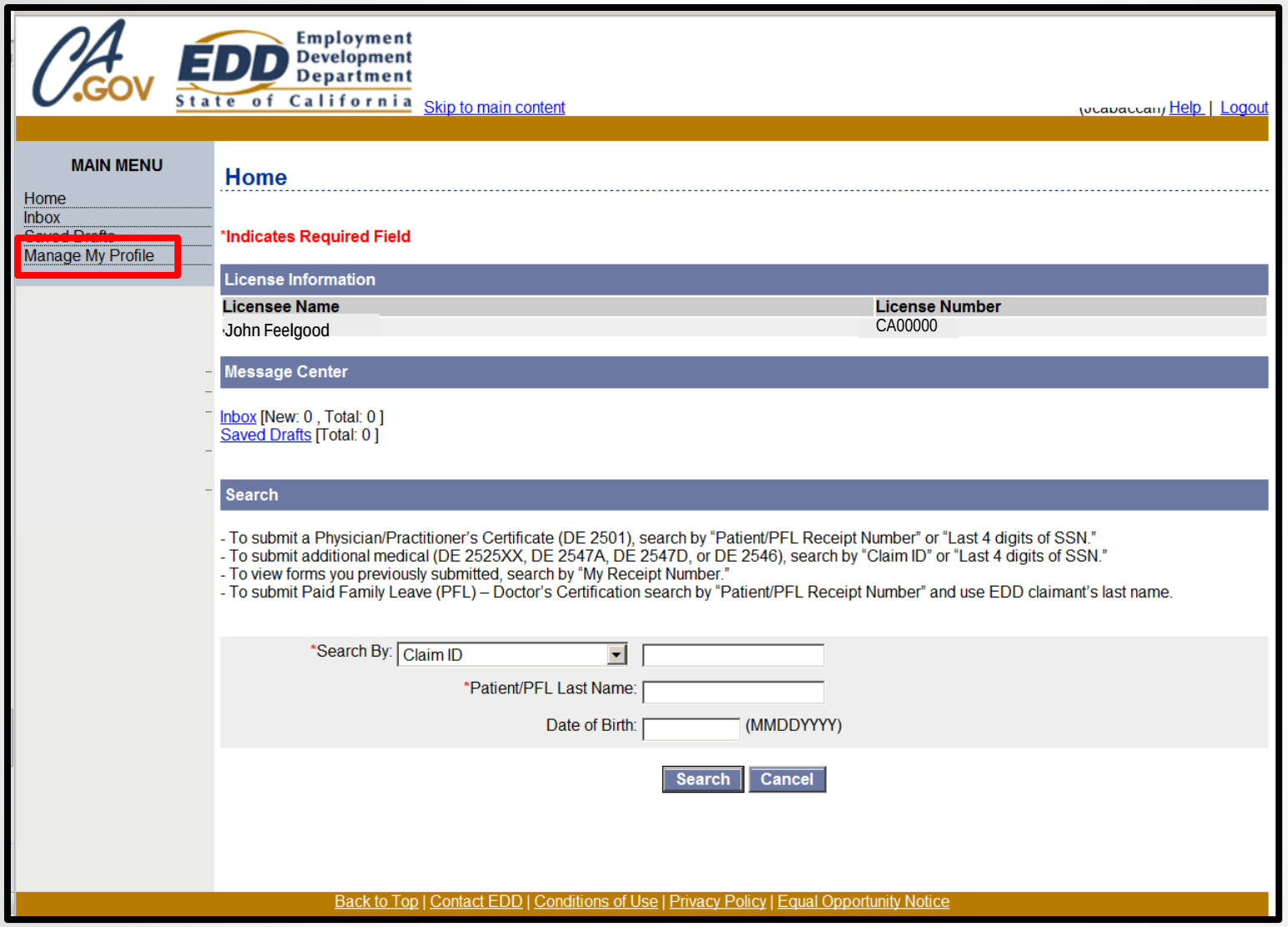
The **Main Menu** appears on most screens and has additional options.

Inbox: Access the Message Center to view messages from the EDD.

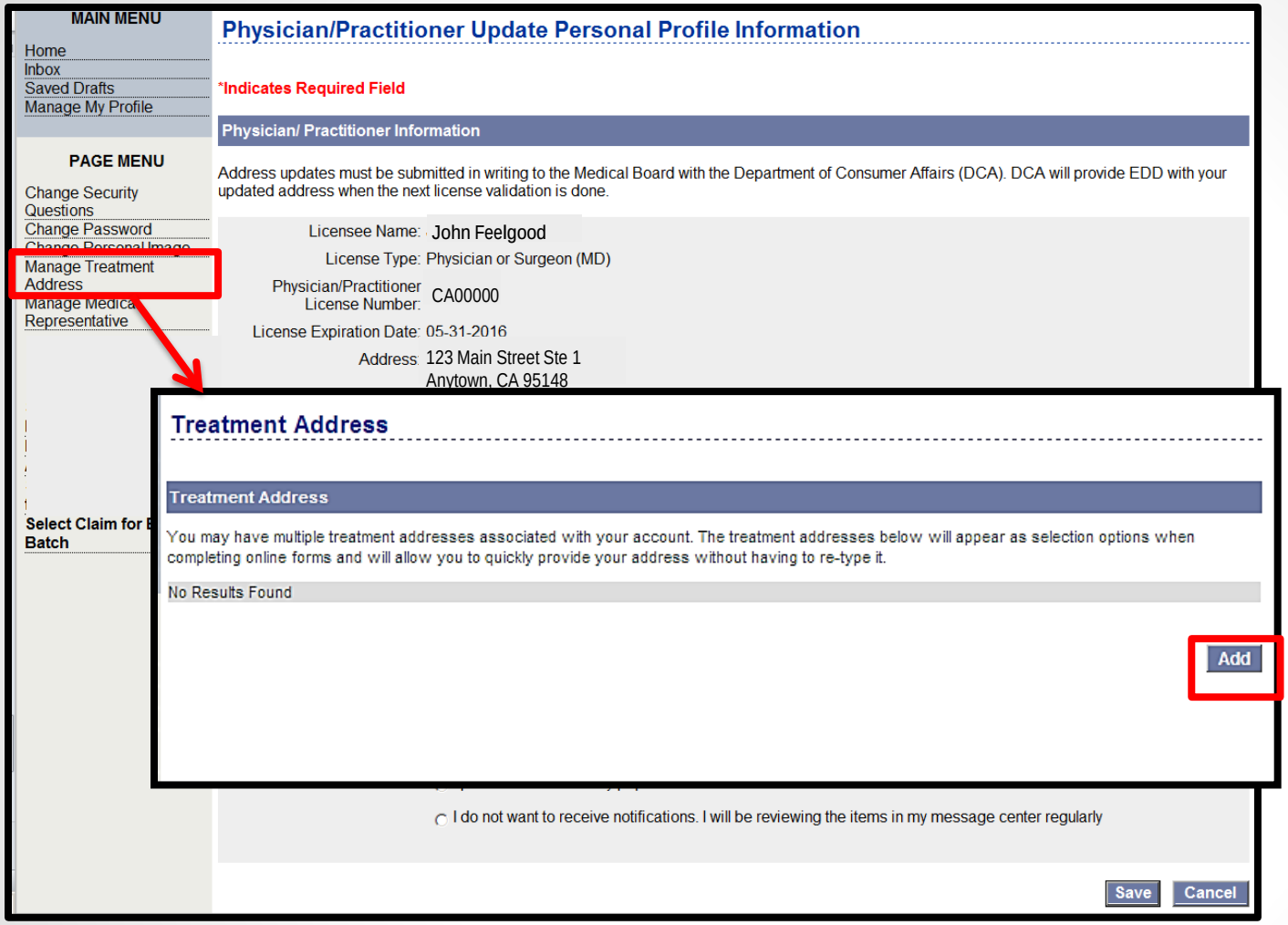
Saved Drafts: View previously saved drafts of forms that were started, but not completed or submitted.

Note: Saved Drafts are deleted after 30 days.

Add a Treatment Address

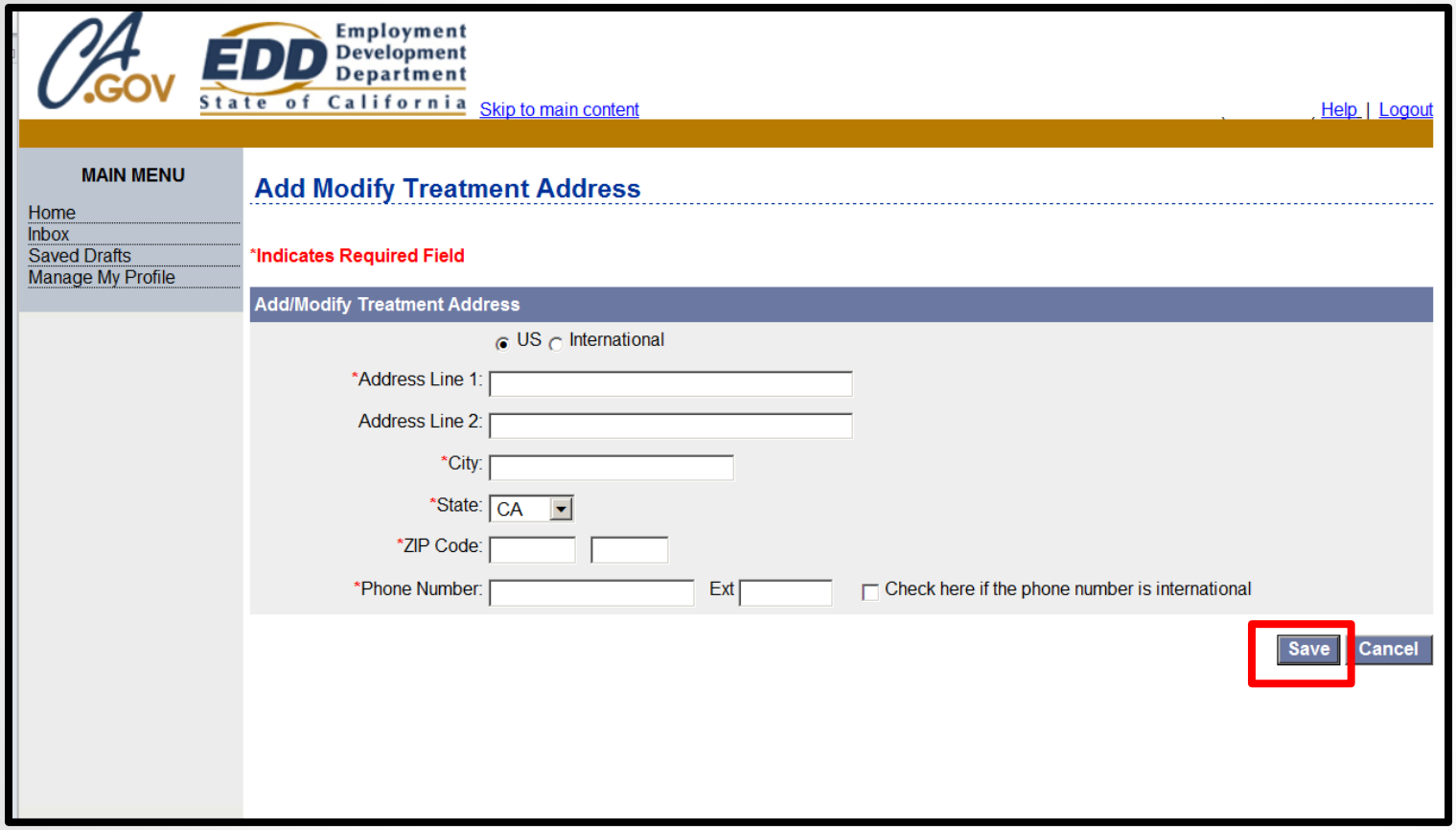


To add a treatment address, select **Manage My Profile** under the **Main Menu** on the **Home** page.



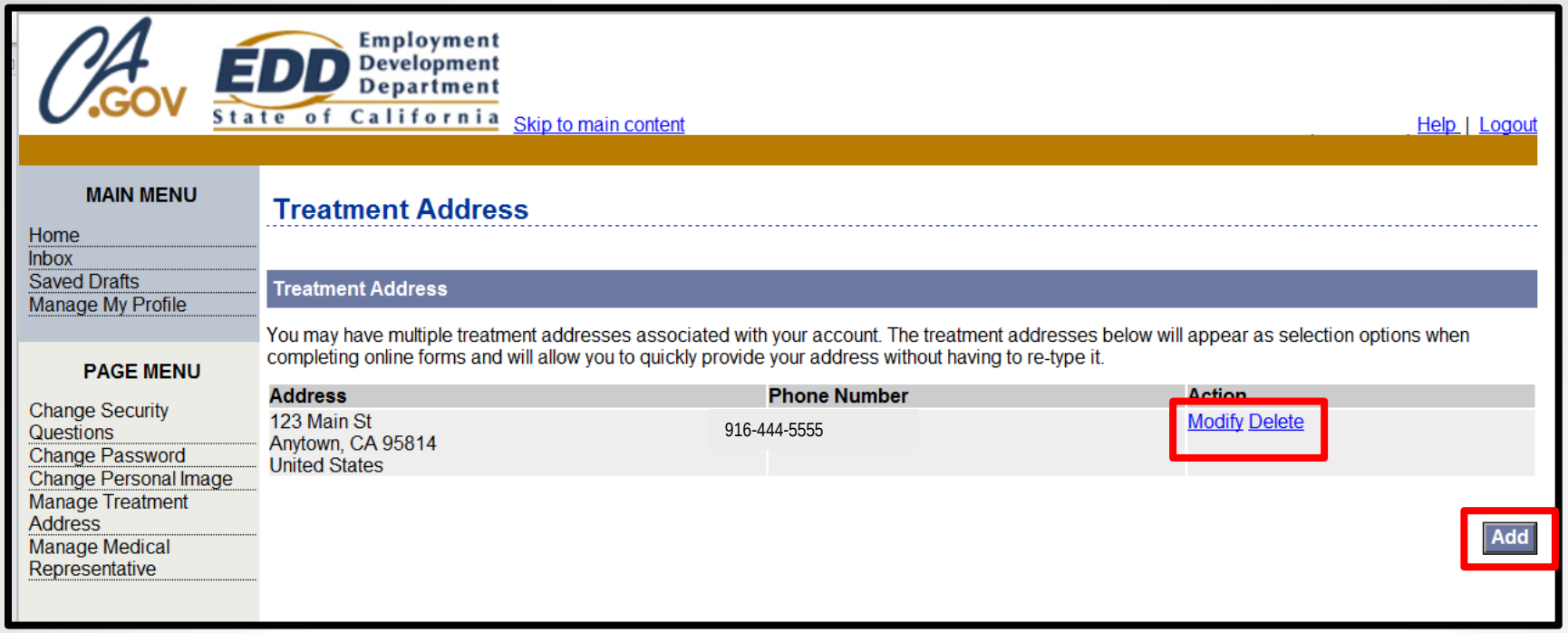
You will be directed to the **Physician/Practitioner Update Personal Profile Information** page.

- Select **Manage Treatment Address** from the Page Menu.
- You can add a treatment address by selecting the **Add** button.



On the **Add Modify Treatment Address** page, complete all fields and select **Save**.

Note: You will need to repeat this process to add all treatment addresses at which you practice.

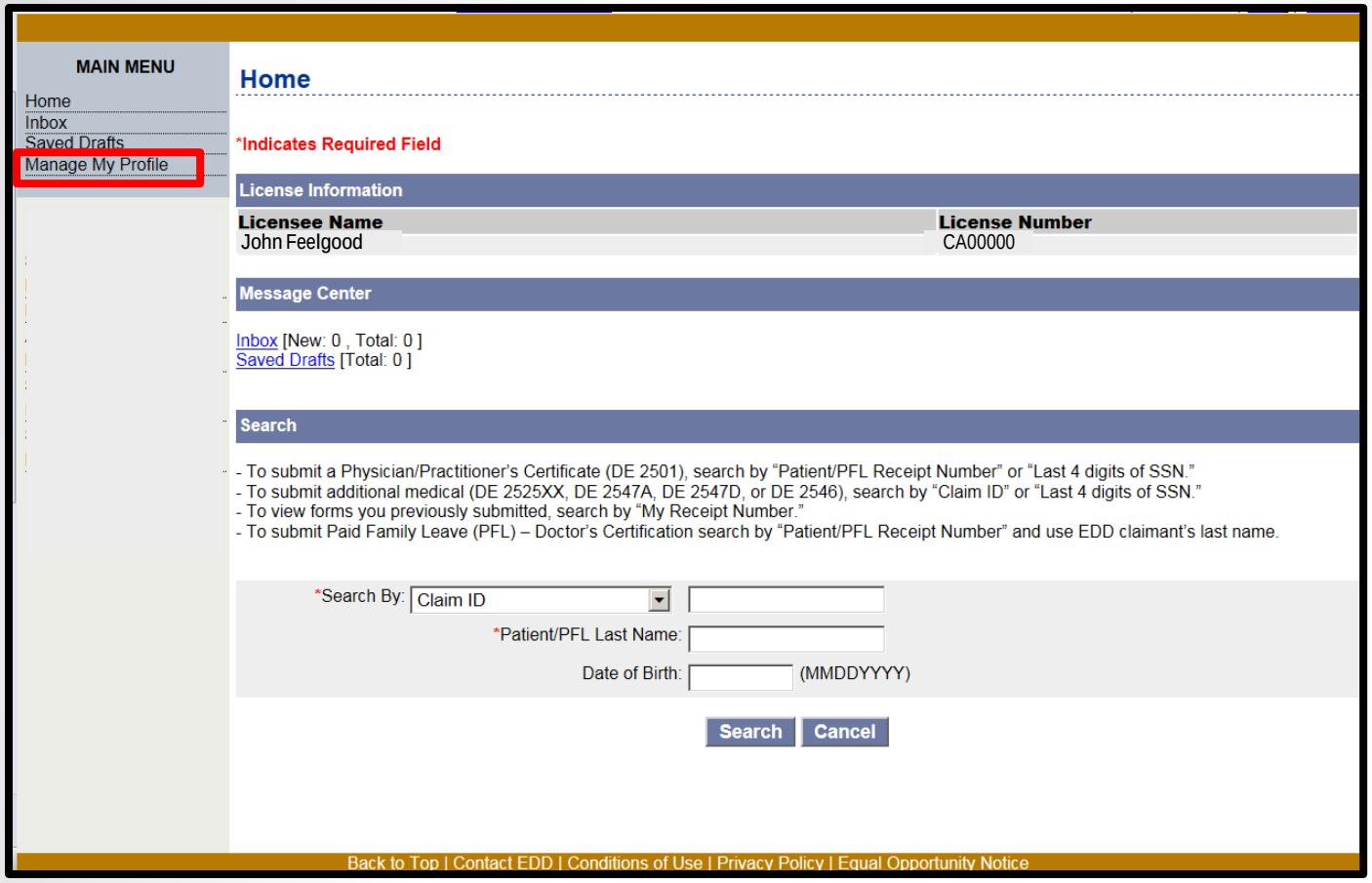


Treatment addresses added are displayed on this page.

Select **Modify** or **Delete** to manage your treatment addresses.

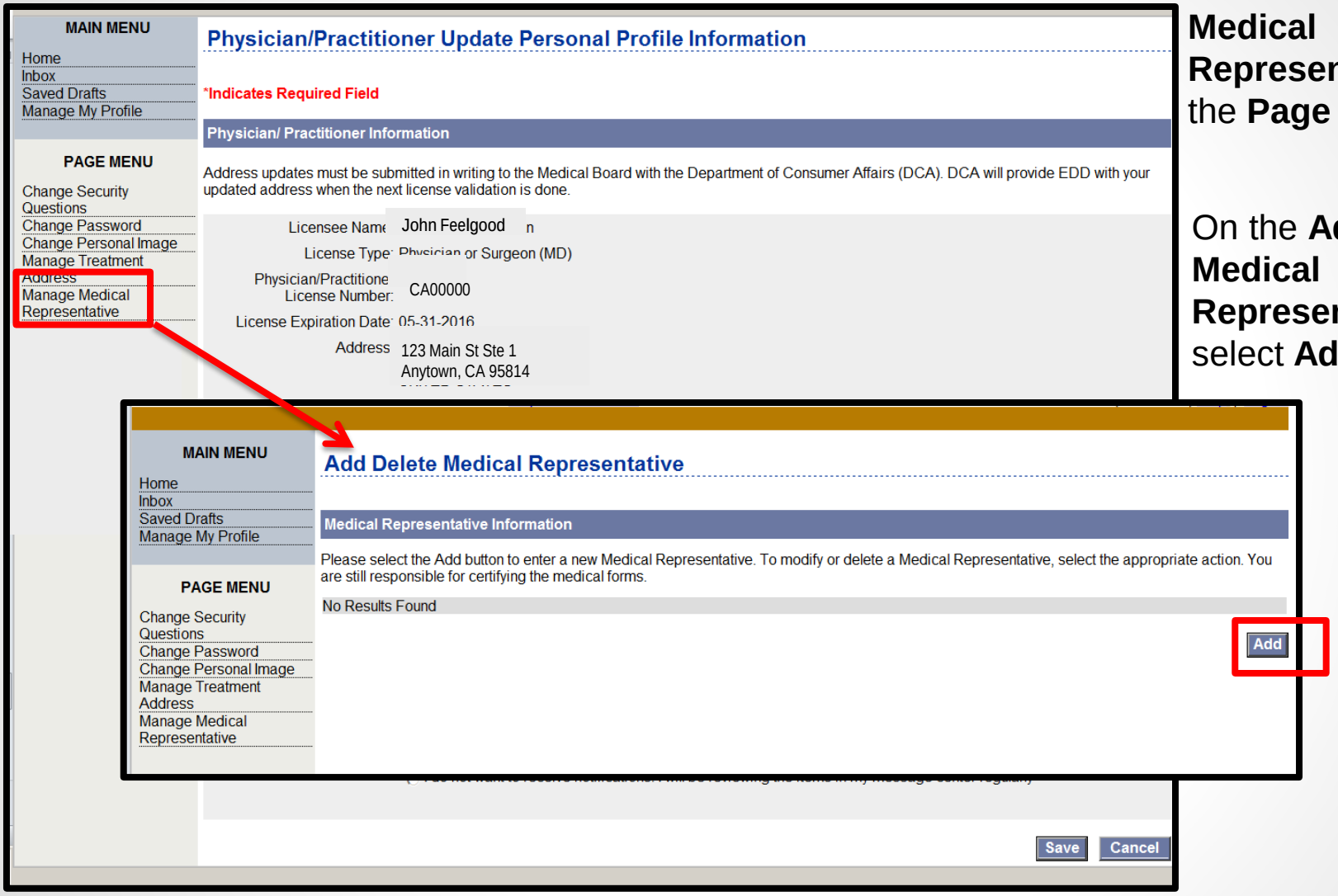
To add additional treatment addresses, select **Add**.

Assign a Physician/Practitioner Representative



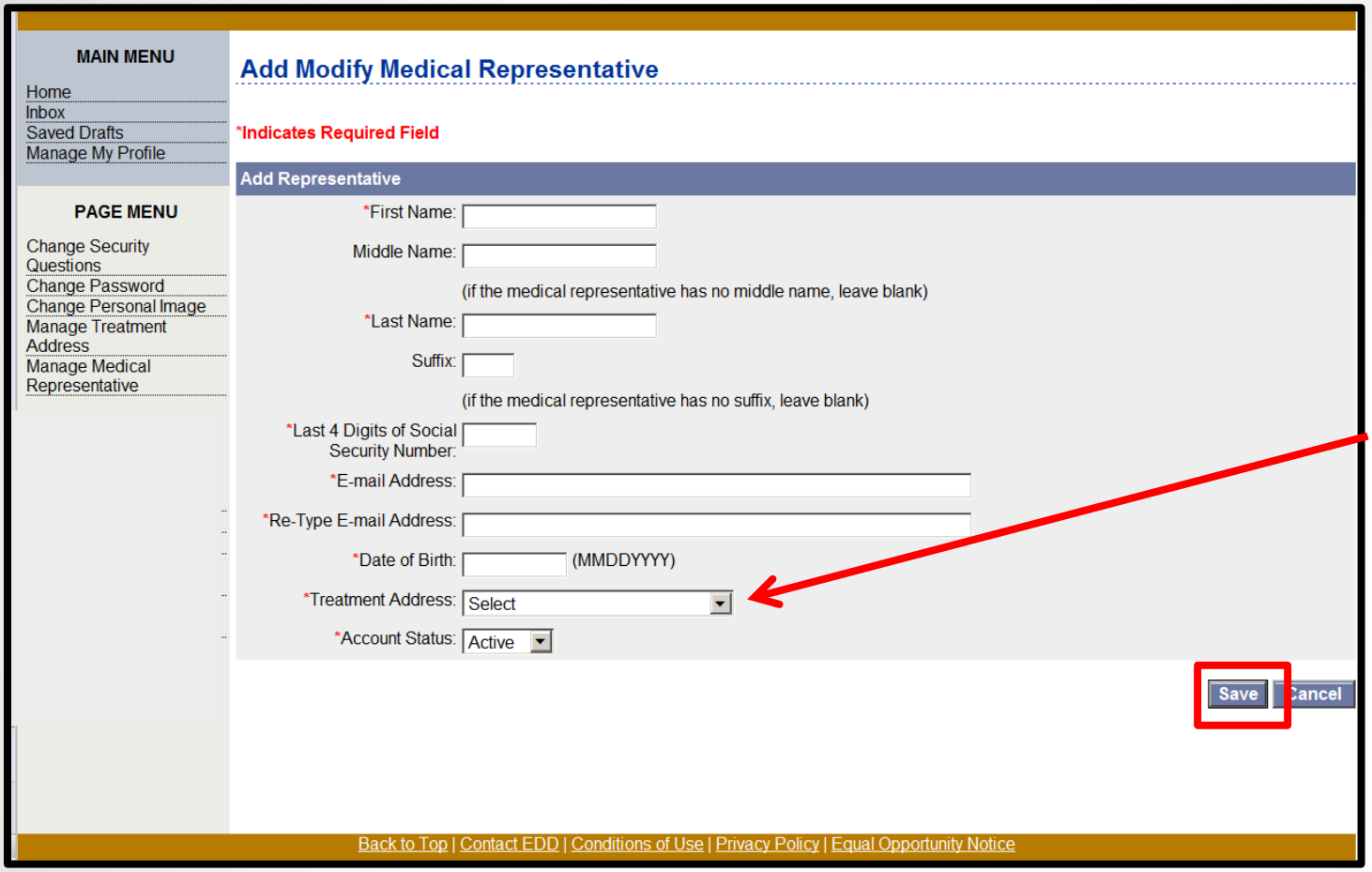
Physician/practitioner representatives can complete and submit forms on behalf of the registered physician/practitioner once they have been added to the account.

To add a physician/practitioner representative, select **Manage My Profile** from the **Main Menu**.

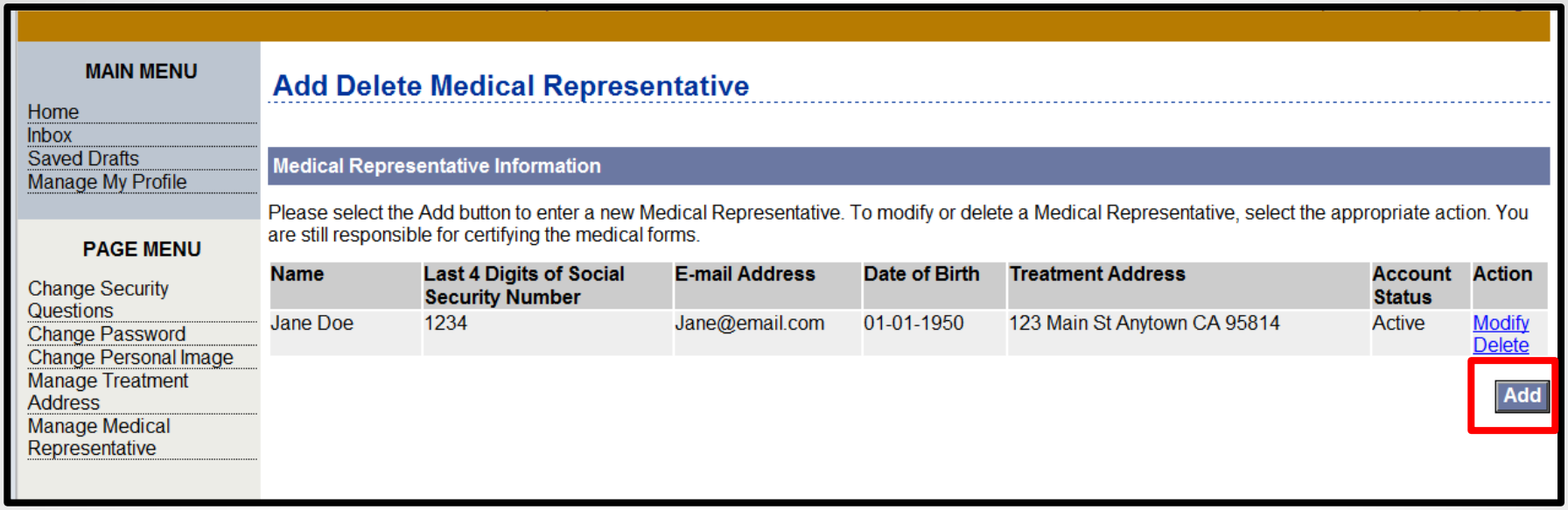


Select **Manage Medical Representative** from the **Page** Menu.

On the **Add Delete Medical Representative** page, select **Add**



Complete the required fields and select a treatment address. Then select **Save**.



Physician/practitioner representatives added are displayed on this page.

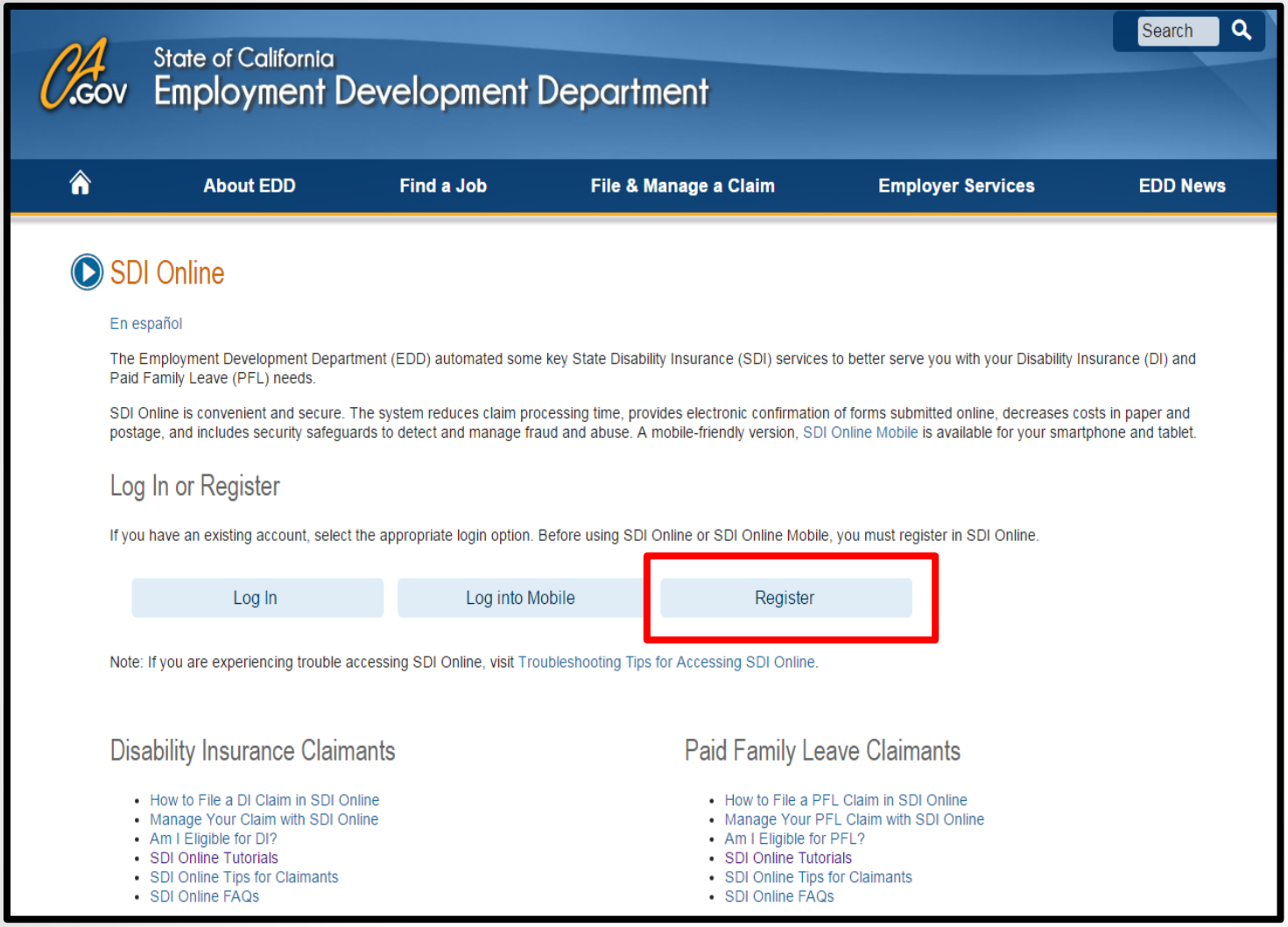
Select **Modify** or **Delete** to manage your medical representatives.

To add additional representatives, select **Add**.

SDI Online Physician/Practitioner Representative Registration

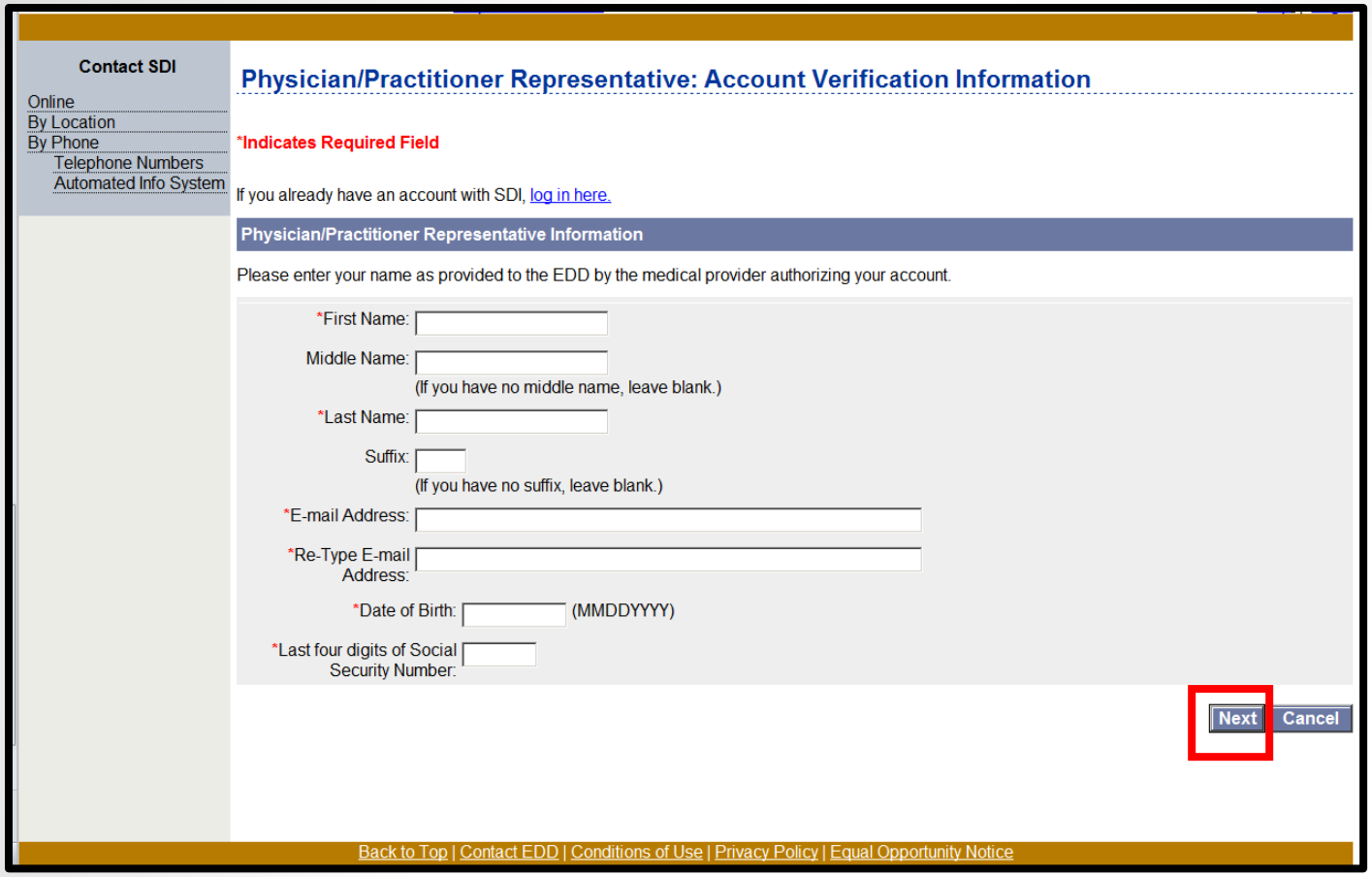
To create an SDI Online account, visit **www.edd.ca.gov/disability**.

On the **State Disability Insurance** overview page, select any **SDI Online** link.

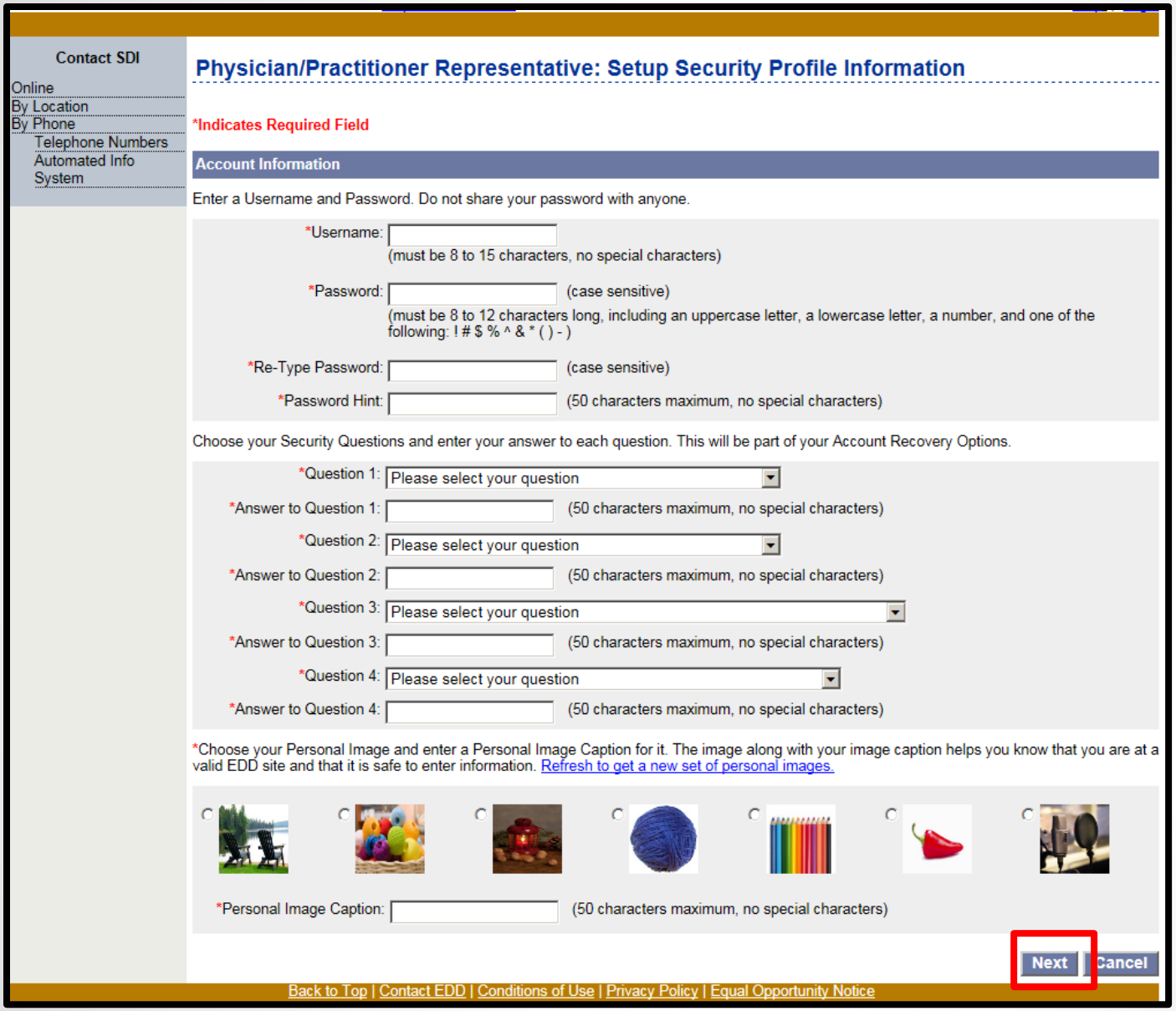


Select the **SDI Online Registration** link to register.

You will be directed to the **SDI Registration Instructions** page. Select **Continue to Physician/Practitioner Representative Registration** and follow the instructions.

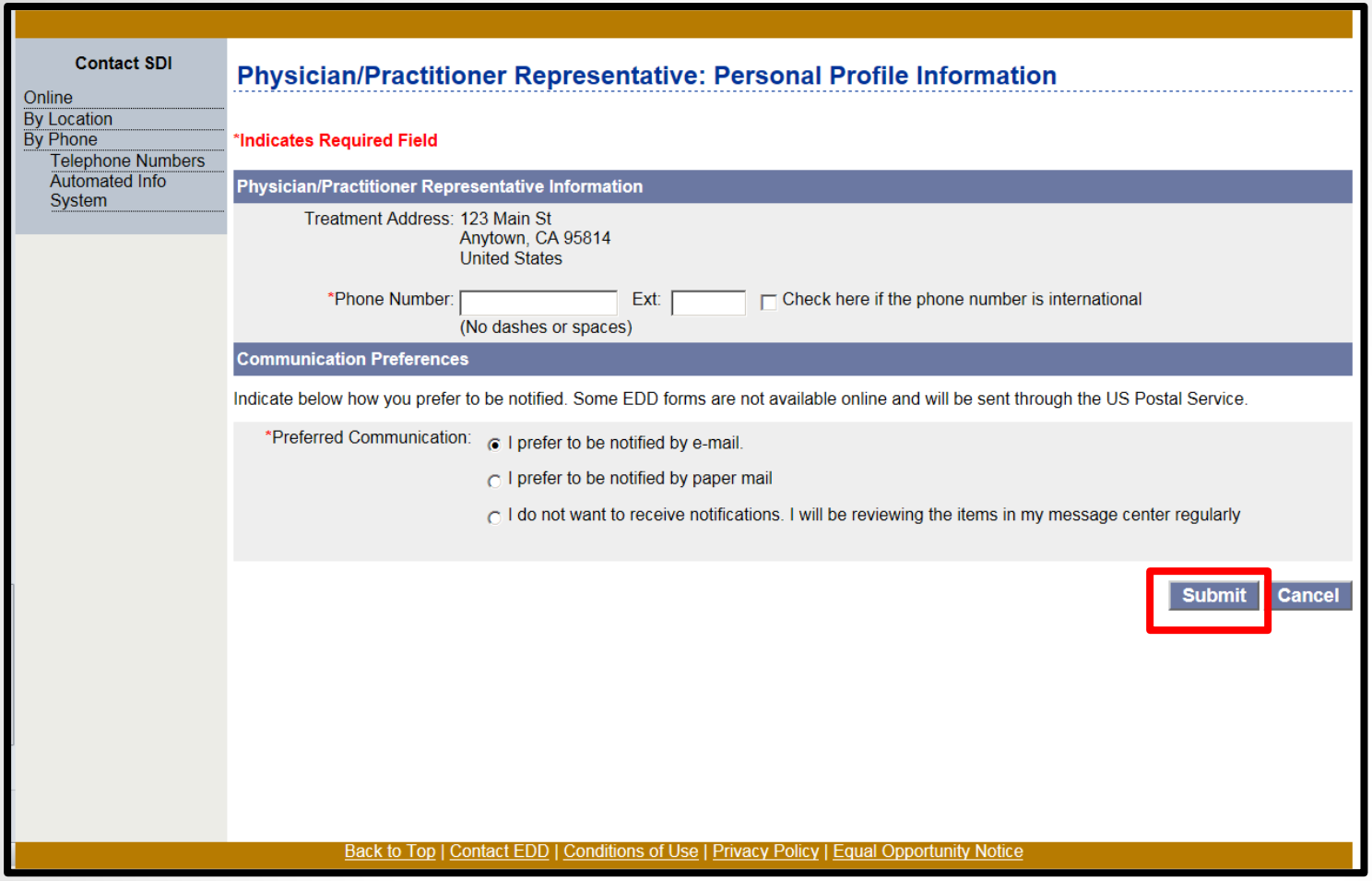


Complete the **Physician/Practitioner Representative Information** section. Be sure to enter your name exactly as provided to the EDD by the physician/practitioner authorizing your account, then select **Next**.



Complete the **Account Information** section by selecting a Username, Password, Personal Image, and Security Questions. Then select **Next**.

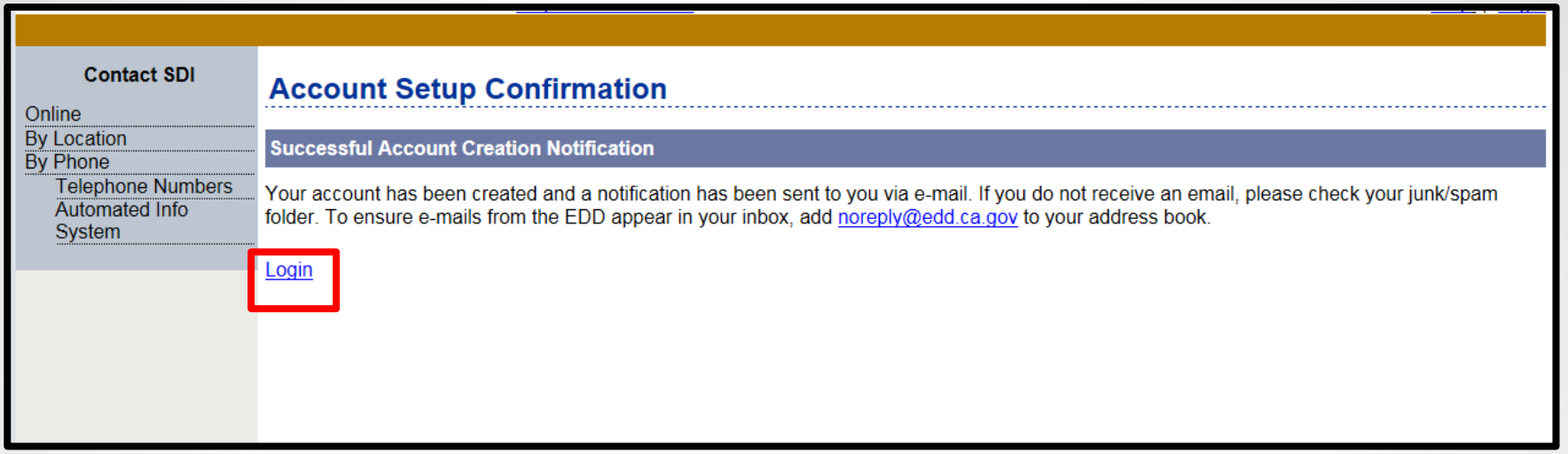
Be sure to make note of this information to ensure easy access when using SDI Online.



Verify the Treatment Address, enter the Phone Number, and select your preferred method of communication.

Select **Submit.**

Note: The physician/practitioner can change the fields that a physician/practitioner representative cannot.



A letter will be mailed to the physician's/practitioner's address to confirm this account has been created.

If you selected electronic communication, a notification will also be sent to you via e-mail.

Select **Login** to access your newly created account.

Submit a DE 2501 Part B – Physician's/Practitioner's Certificate

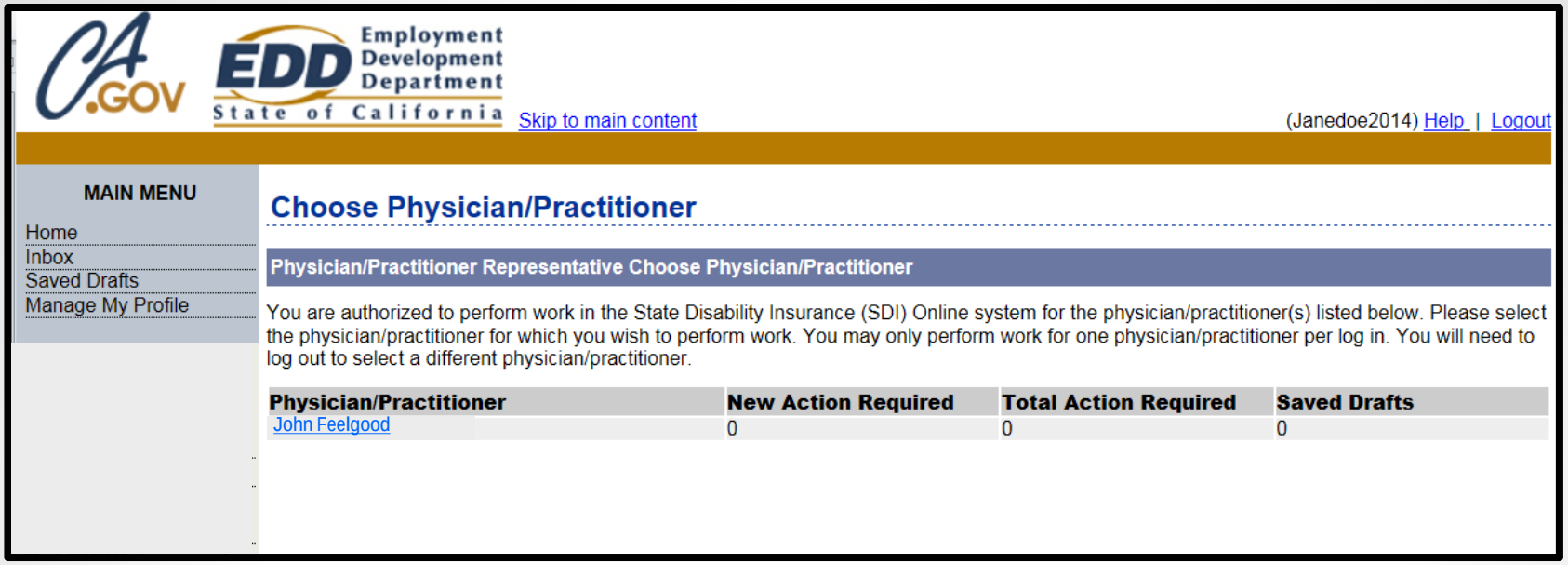
Physicians/Practitioners

On the **Home** page, under the **Search** section, there are two ways to begin searching for the DE 2501B to find your patient's claim:

- Search by "Patient Receipt Number."
- Search by the last four digits of the patient's SSN and Date of Birth.

You must also enter the patient's last name to begin the search.

In order to submit the DE 2501 Part B online, the patient must have already submitted the DE 2501 Part A – Claimant's Statement.

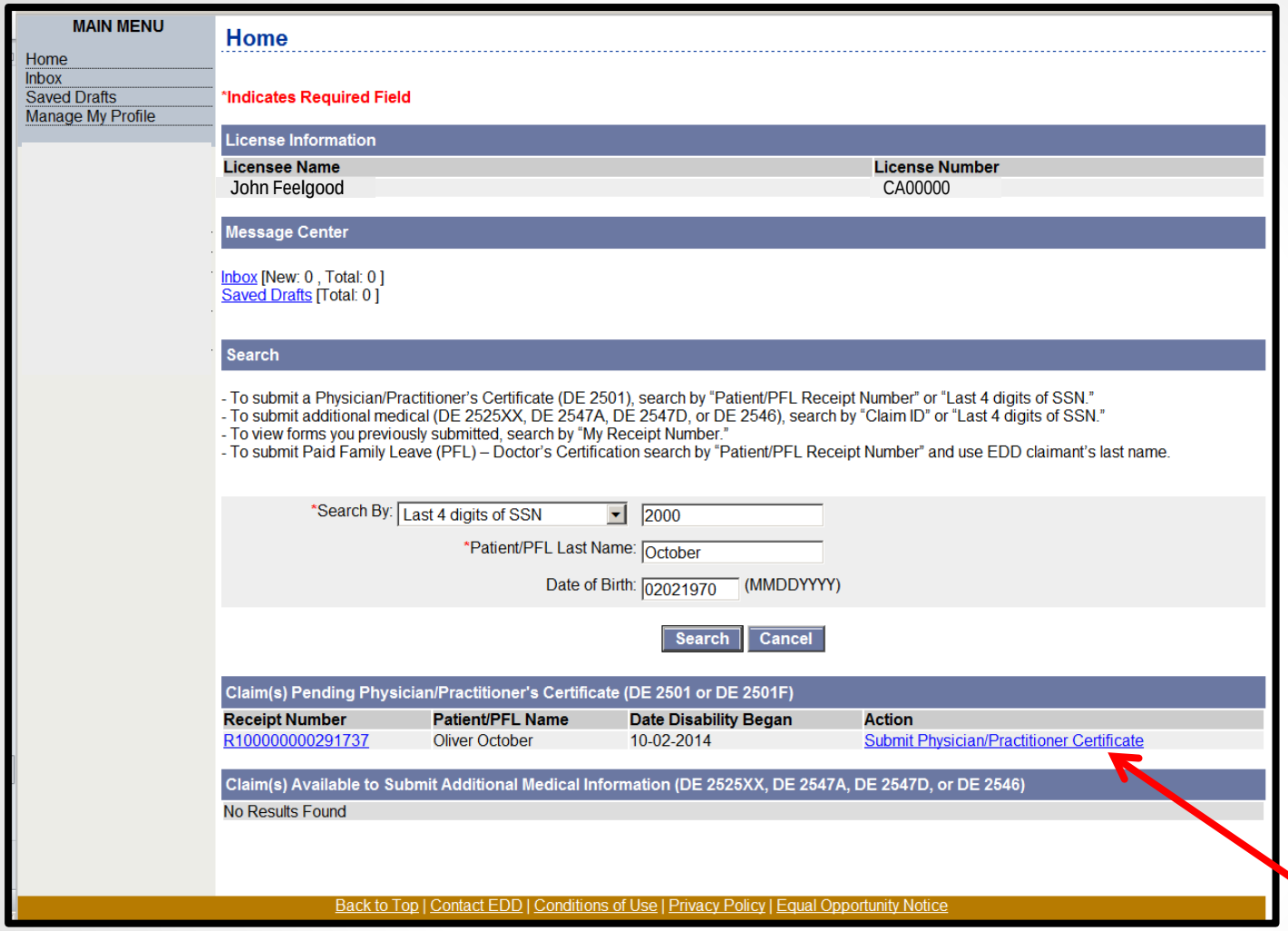


Physician/Practitioner Representatives

On the **Home** page, select the physician/practitioner you are submitting the DE 2501B on behalf of.

You may select only one physician/practitioner at a time.

You may switch to a different physician/practitioner account by selecting **Home** from the Main Menu and selecting **Choose Physician/Practitioner**.



Select a preferred search method from the **Search By** drop down menu.

Verify the information in the **Search Results** section matches the patient's records.

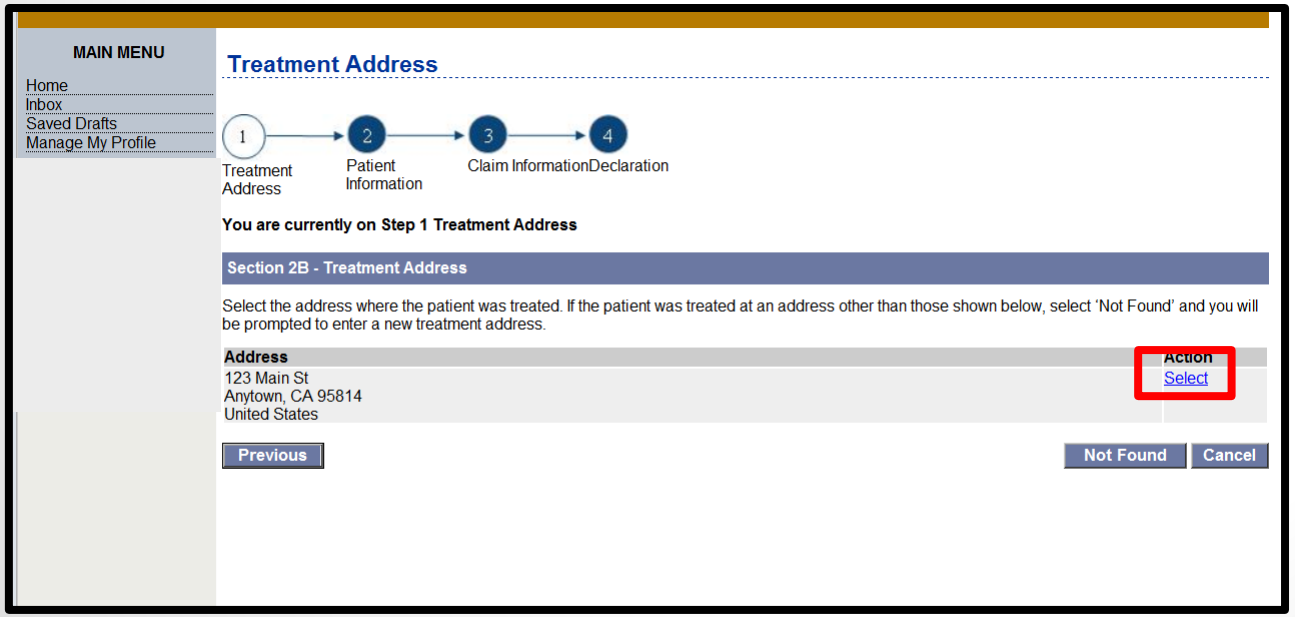
The **Receipt Number** link will allow you to view what the patient submitted on their portion of the DE 2501 Part A – Claimant's Statement.

Select the **Submit Physician/Practitioner Certificate** link under the Action column.

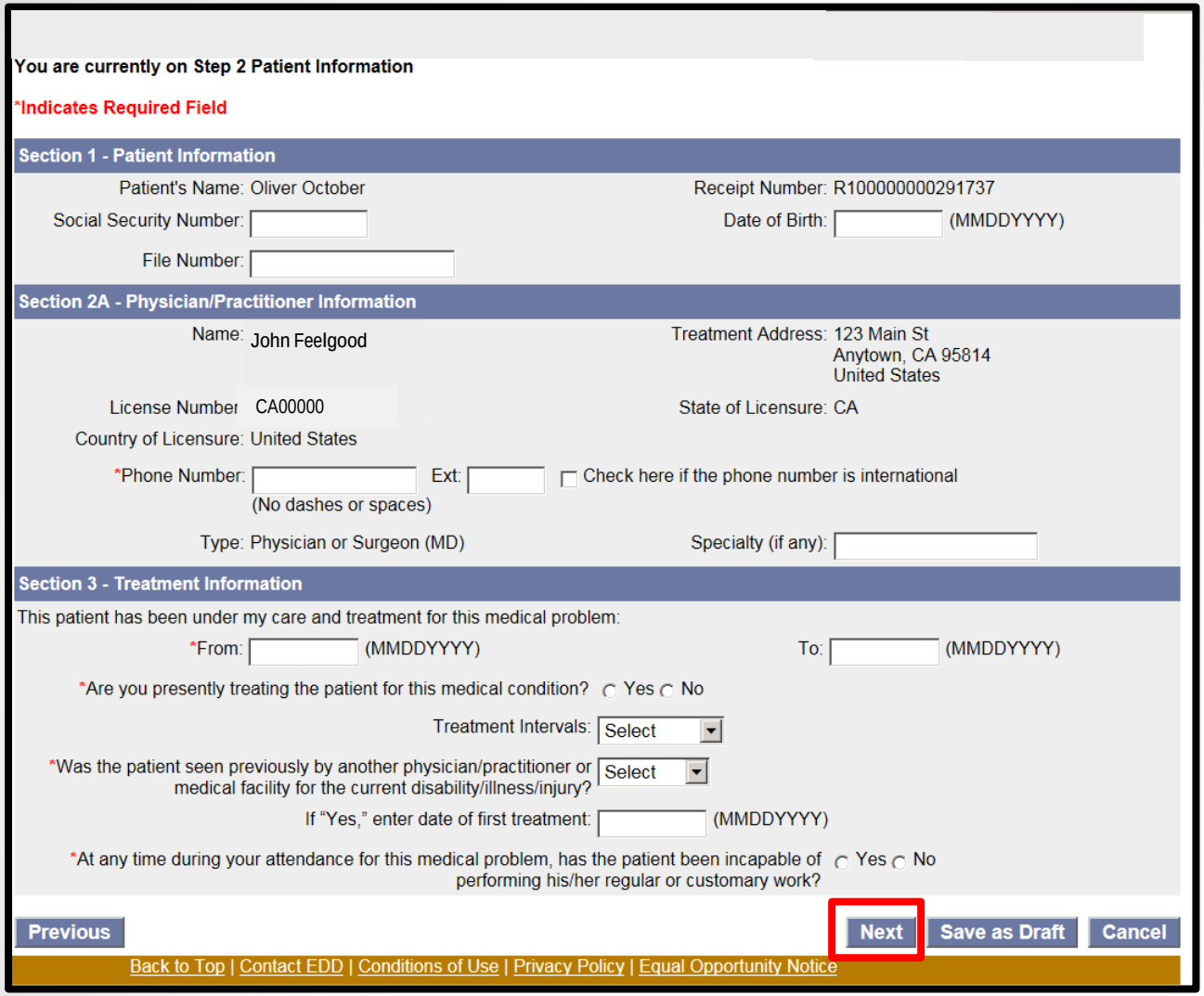
Note: If the Certificate is already submitted by another user (i.e., physician/practitioner representative), the **Submit Physician/Practitioner Certificate** link will not be available.

On the **View Claimant Portion,** you may select the link to view the claimant portion of the form.

Select **Next** to complete the certificate.



On the **Treatment Address** page, select the treatment address of where the patient is being treated.

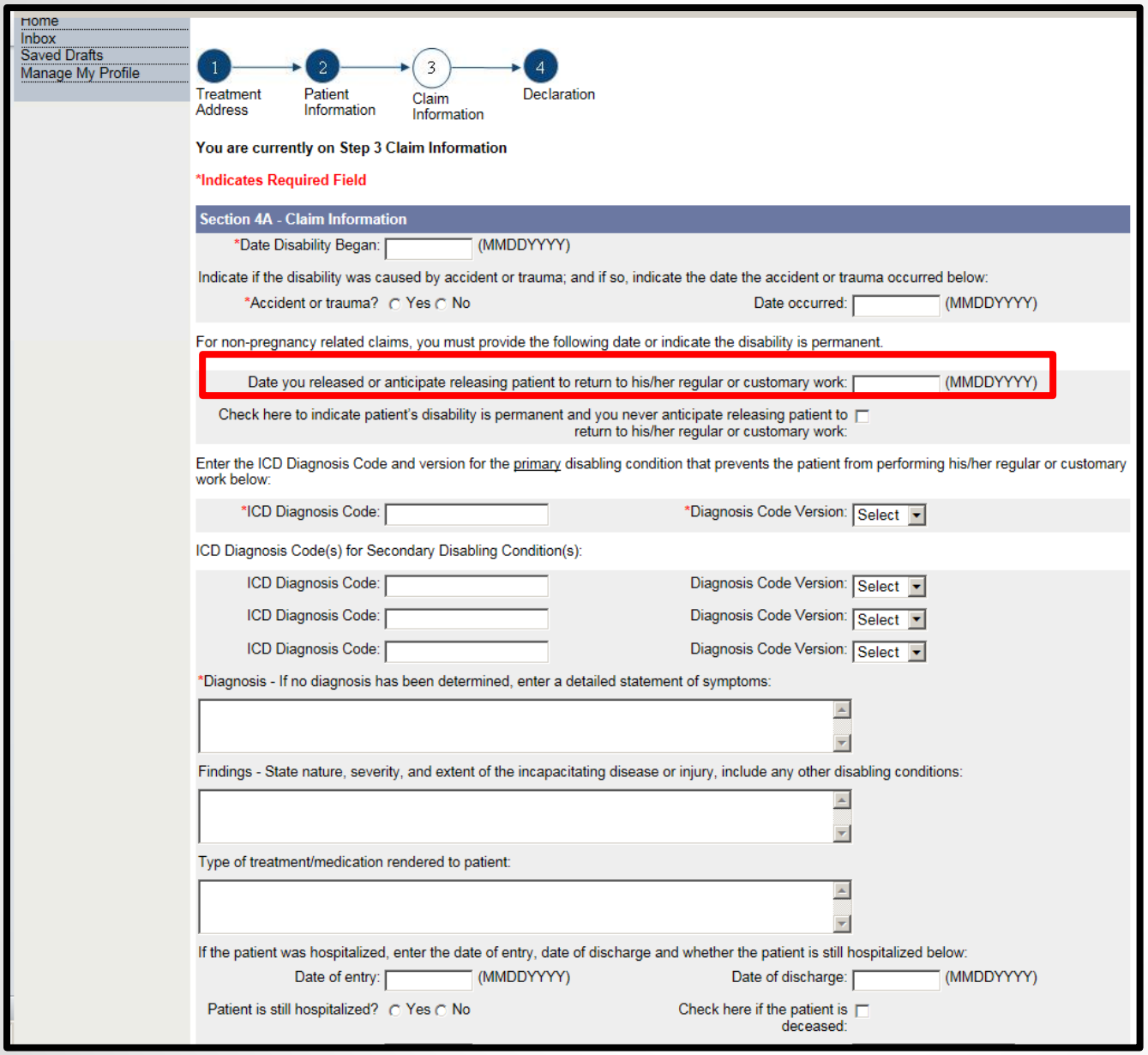


Complete the **Patient Information** section and select **Next**.

Mandatory fields are marked with a red asterisk (*).

Tip: Select **Save as Draft** at any point in the process to complete the form at a later time.

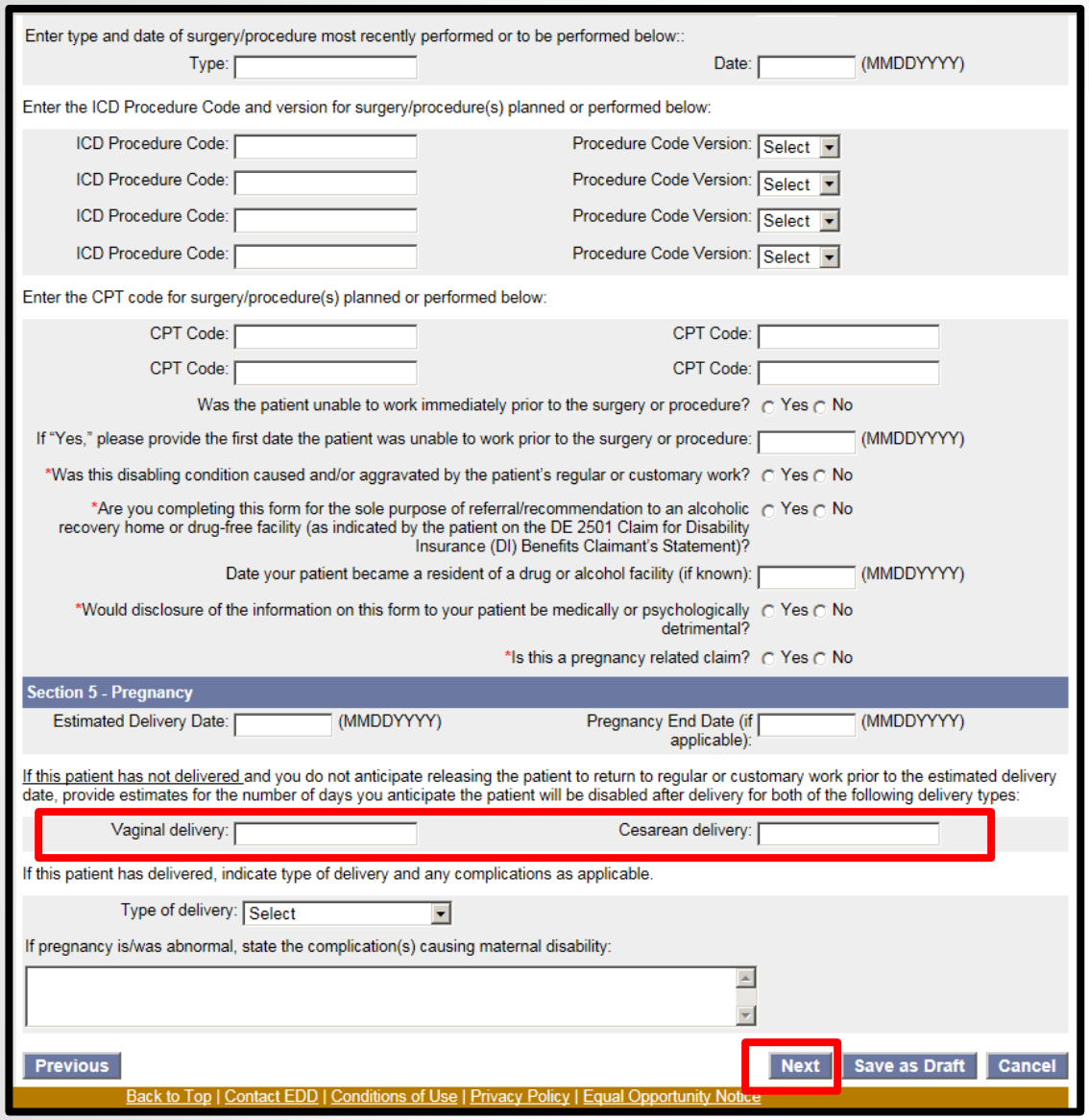
Note: Do not use the Back button on the browser. If you need to go to a previous screen, select the **Previous** button.



SDI Online will accept valid ICD-9 and ICD-10 codes.

If the patient's disability is diagnosed as permanent and you have selected the "permanent disability" box, you do **not** need to provide a date in the "Date you released or anticipate releasing patient to return to his/her regular or customary work" field.

In the "Findings" field, please provide a detailed description of why you consider the disability to be permanent.



Physicians/Practitioners can provide an estimated number of days they anticipate the patient to be disabled postpartum.

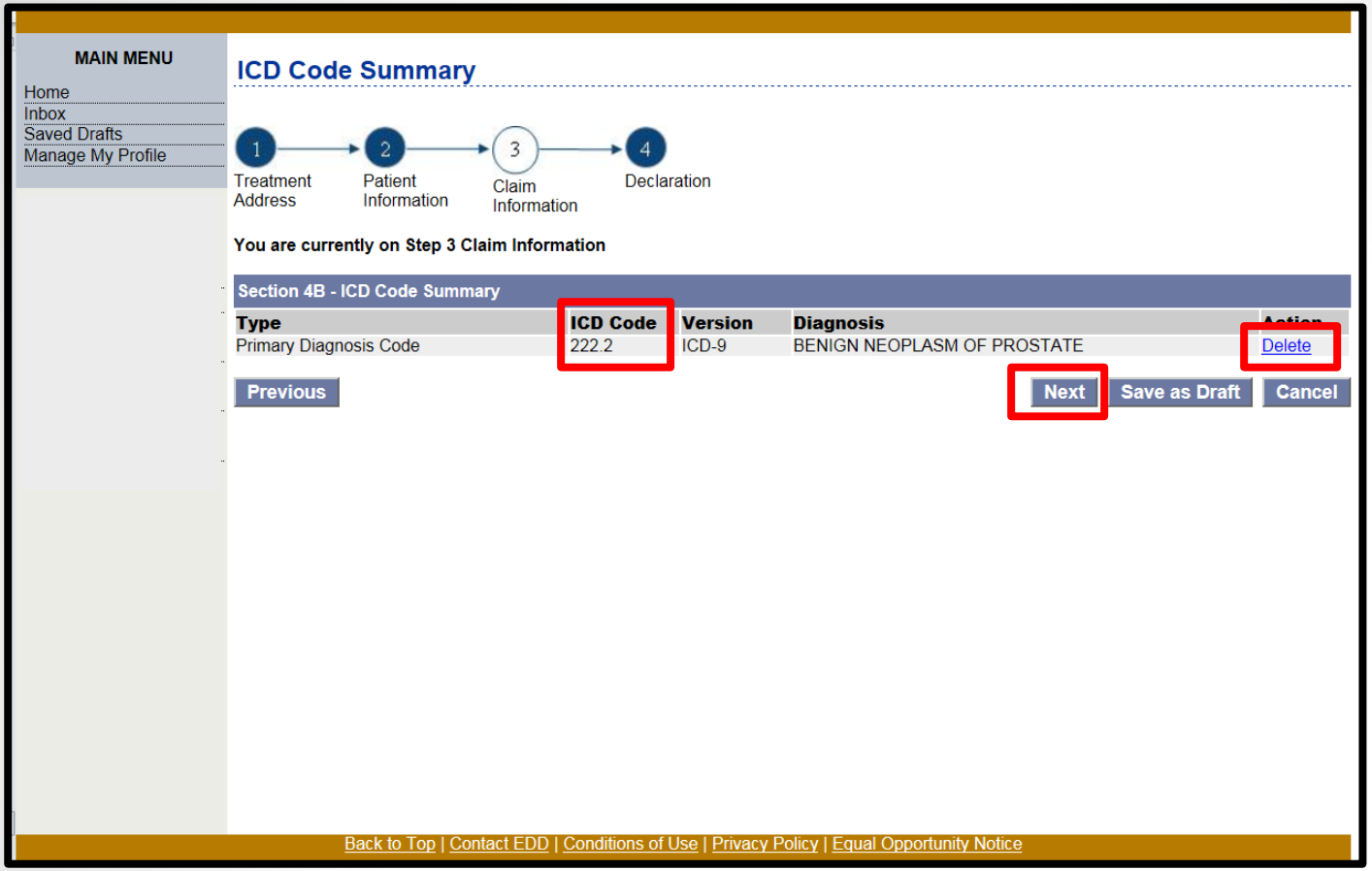
- Example: If the physician/practitioner allows the patient 6-8 weeks of postpartum disability, depending on the delivery type, then:

  - Enter the number 42 in the Vaginal Delivery field (6 weeks x 7 days a week = 42)

  OR

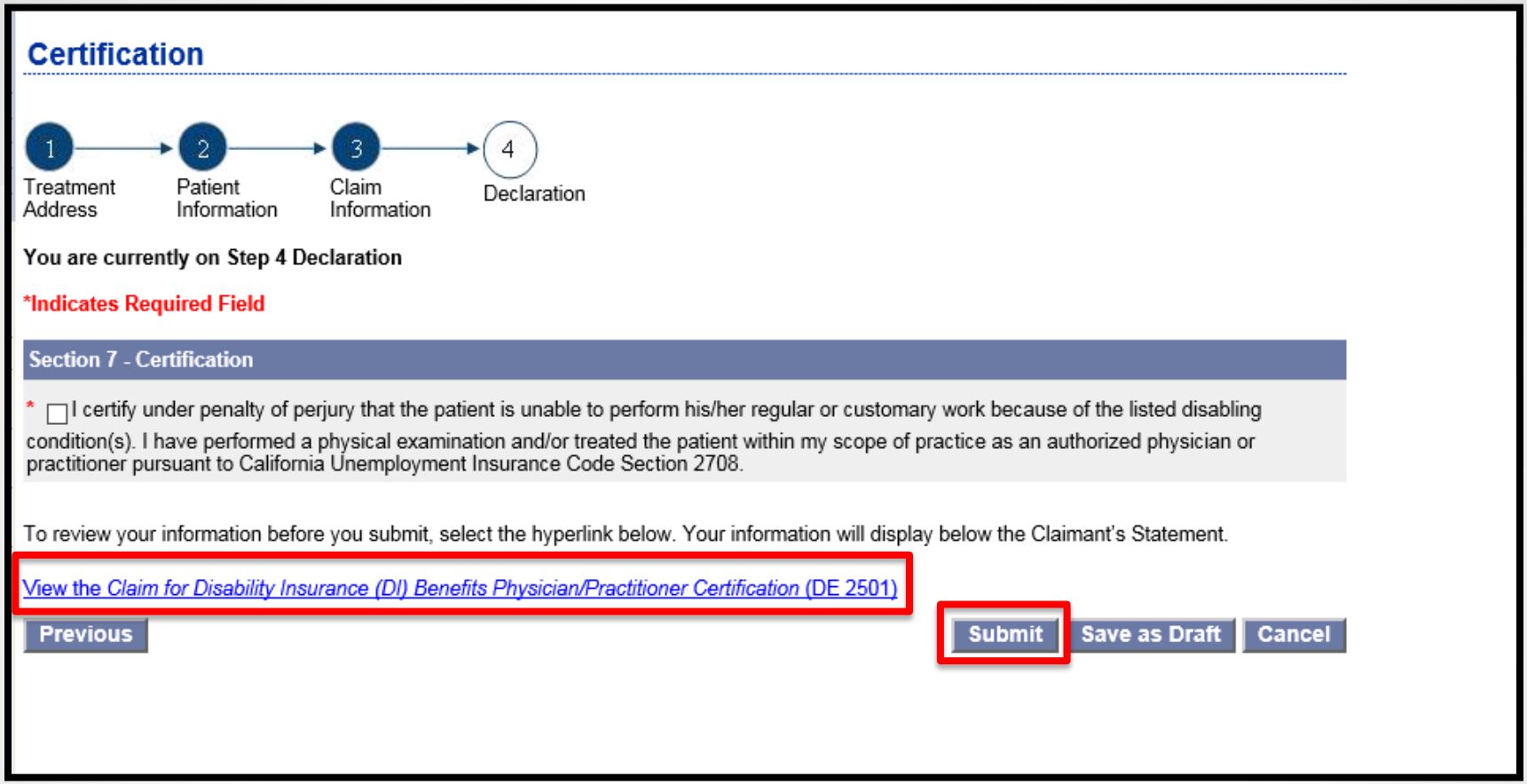
  - Enter the number 56 in the Cesarean Delivery field (8 weeks x 7 days a week = 56).

Select **Next**.



Verify the ICD code(s) is correct for the claim and select **Next**.

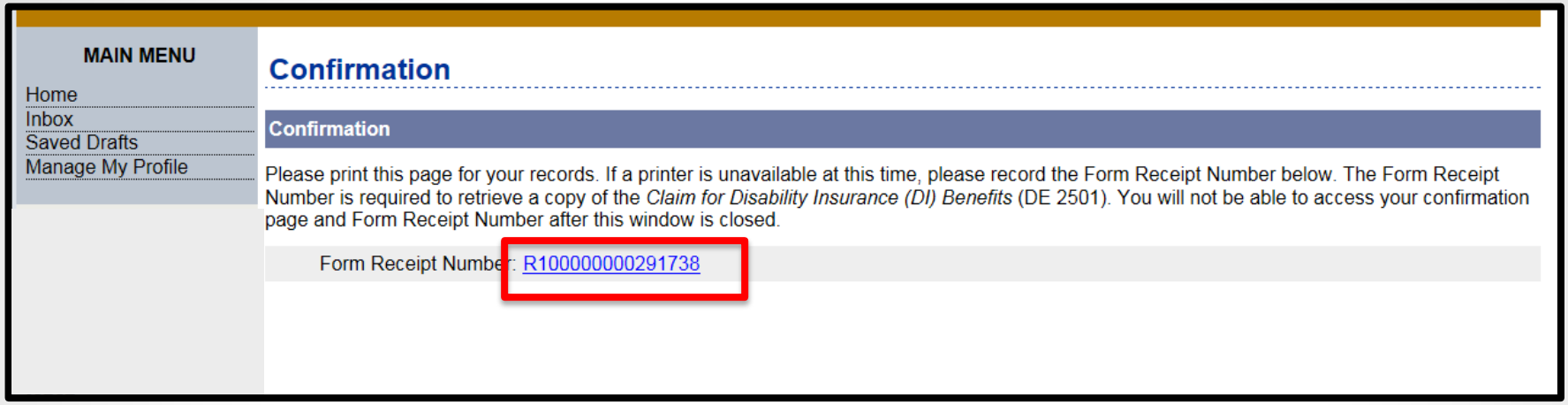
If it is not correct, select **Delete** and re-input the correct code(s) in the **Claim Information** section.



Once the form is completed, select the box in the **Certification** section to authorize an electronic signature.

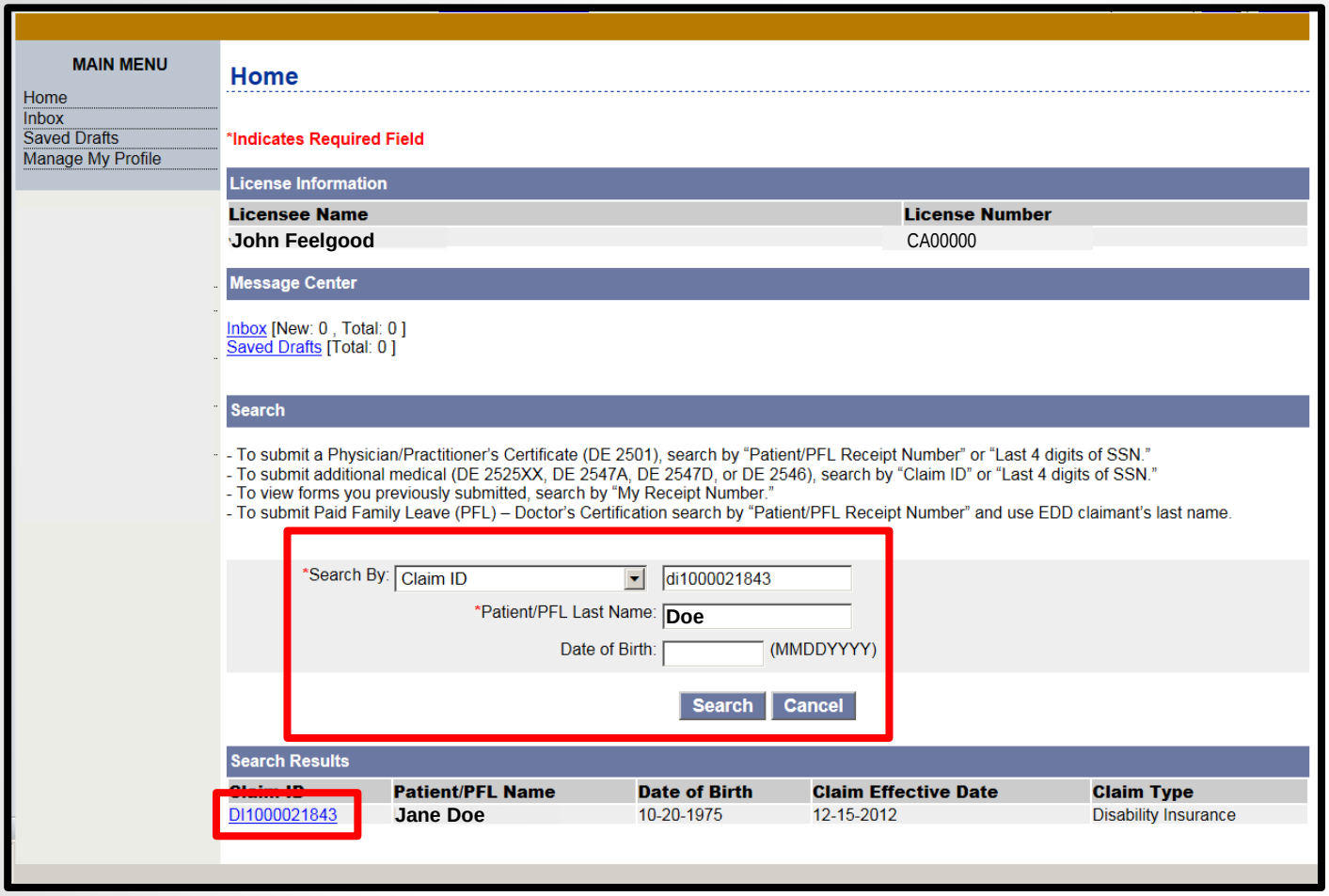
Before submitting the form, you may view the form by selecting the link at the bottom of the page.

Select **Submit**. You will be directed to the **Confirmation** page and provided a Form Receipt Number.



On the **Confirmation** screen, select the **Form Receipt Number** link to open a PDF printer-friendly view of the information that is submitted.

Submit a Supplementary Certificate for Continued Benefits, DE 2525XX

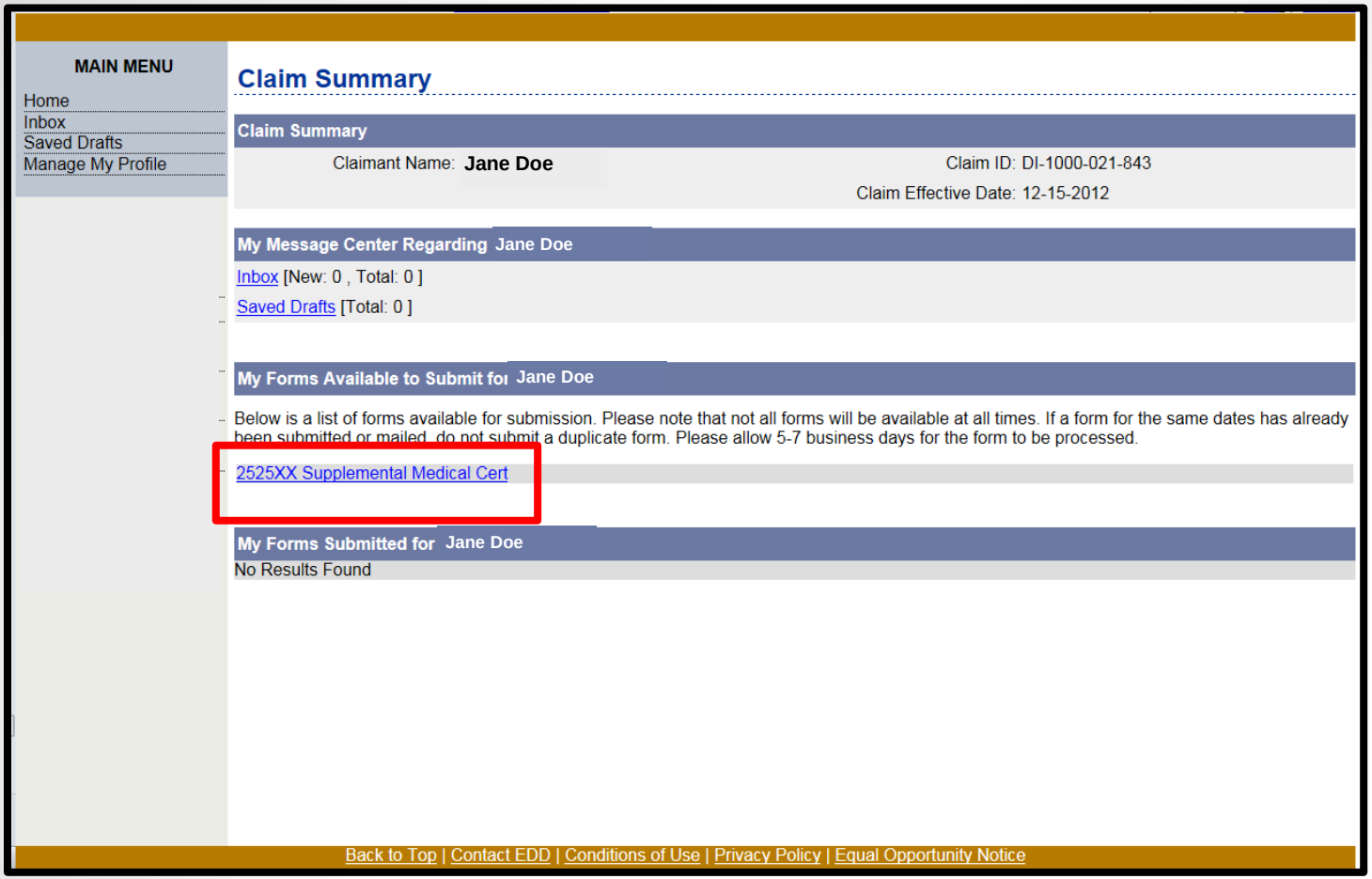


On the **Home** page, to submit a DE 2525XX – Supplementary Certificate:

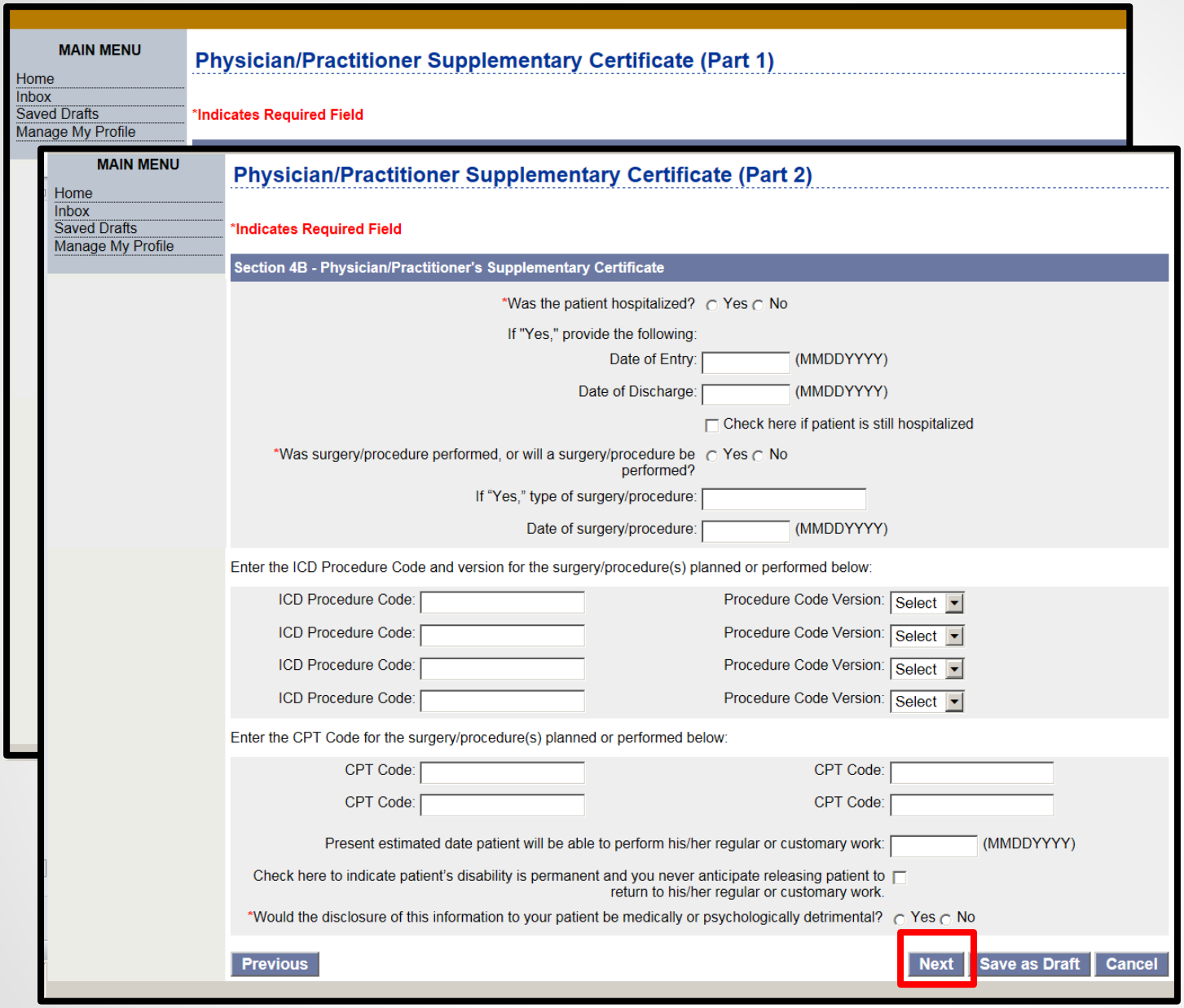
Select a preferred search method from the **Search By** drop down menu.

Verify the information in the **Search Results** section matches the patient's records.

Then select the **Claim ID** link.

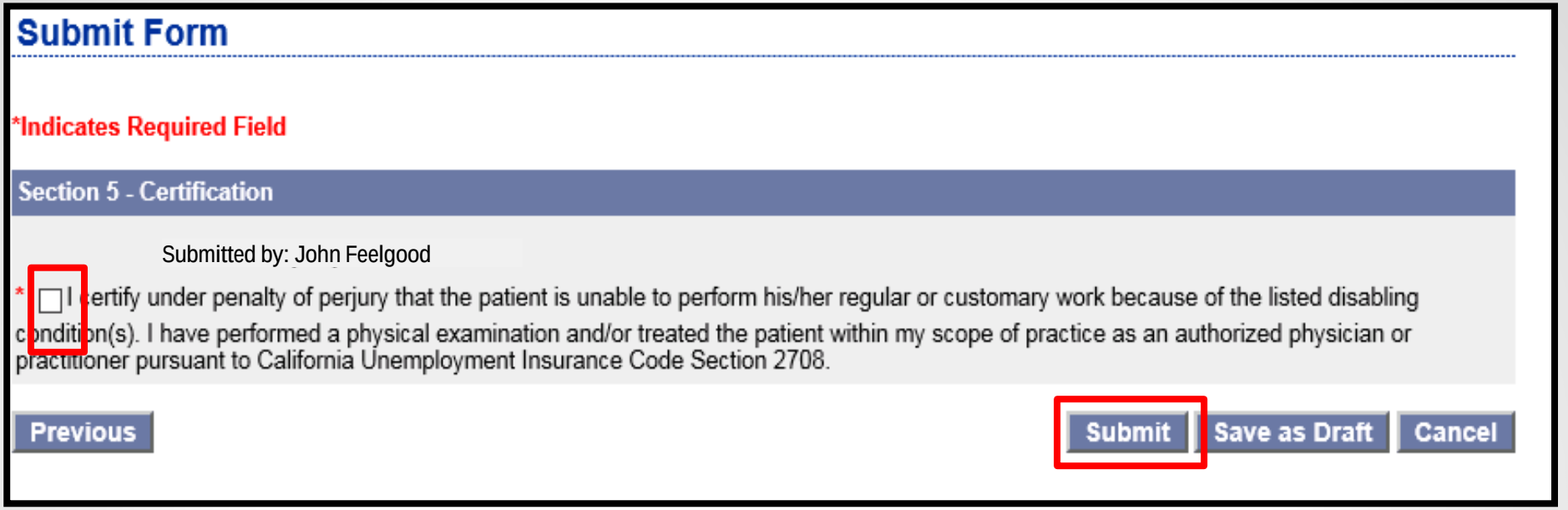


Under the **My Forms Available to Submit** section, select the **2525XX Supplemental Medical Cert** link.



Complete the **Physician/ Practitioner Supplementary Certificate** parts and select **Next**.

Mandatory fields are marked with a red asterisk (*).

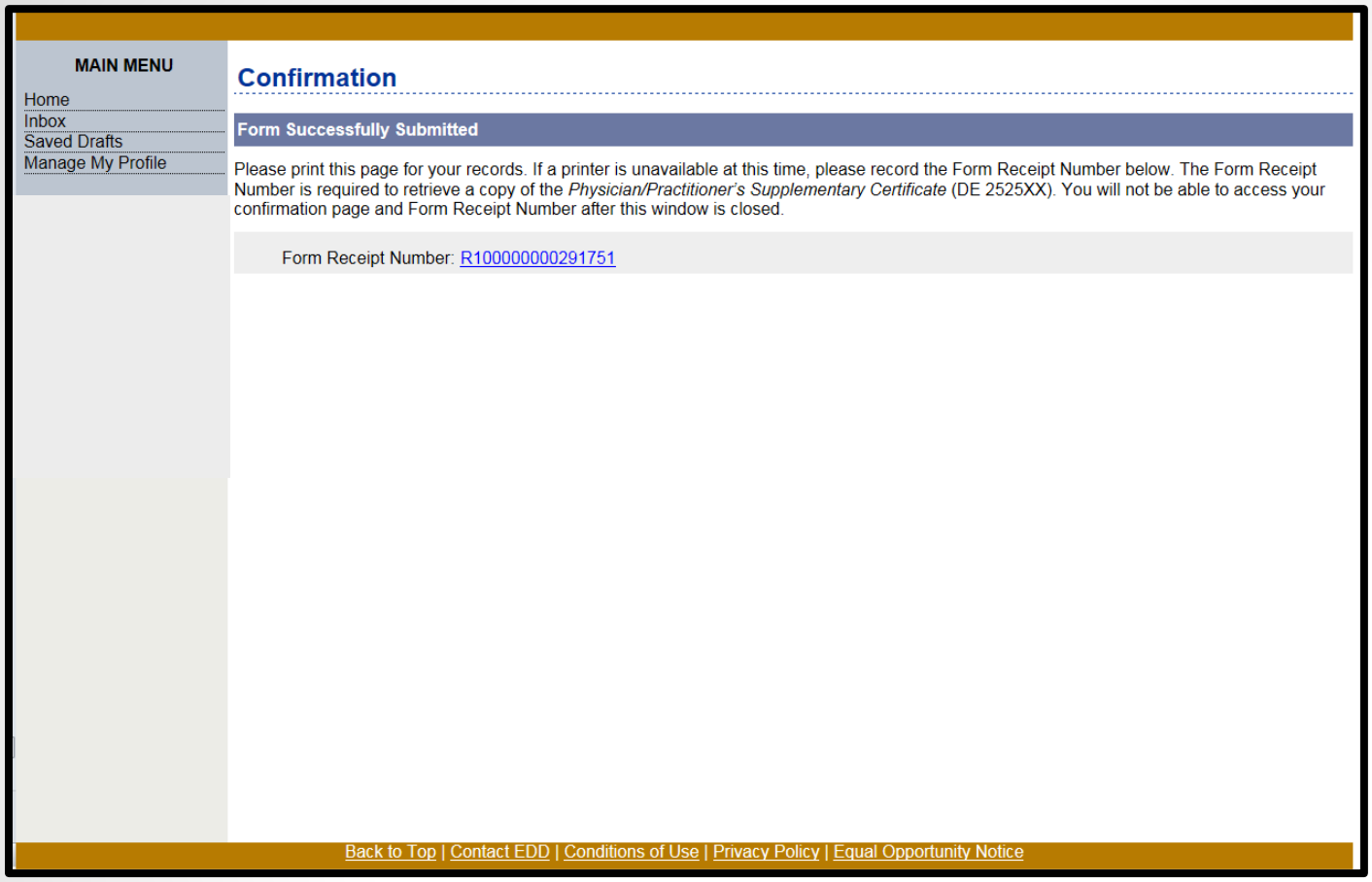


Once the form is completed, select the box in the **Certification** section that best describes your role to authorize an electronic signature.

Before submitting the form, you may view the form by selecting the link at the bottom of the page.

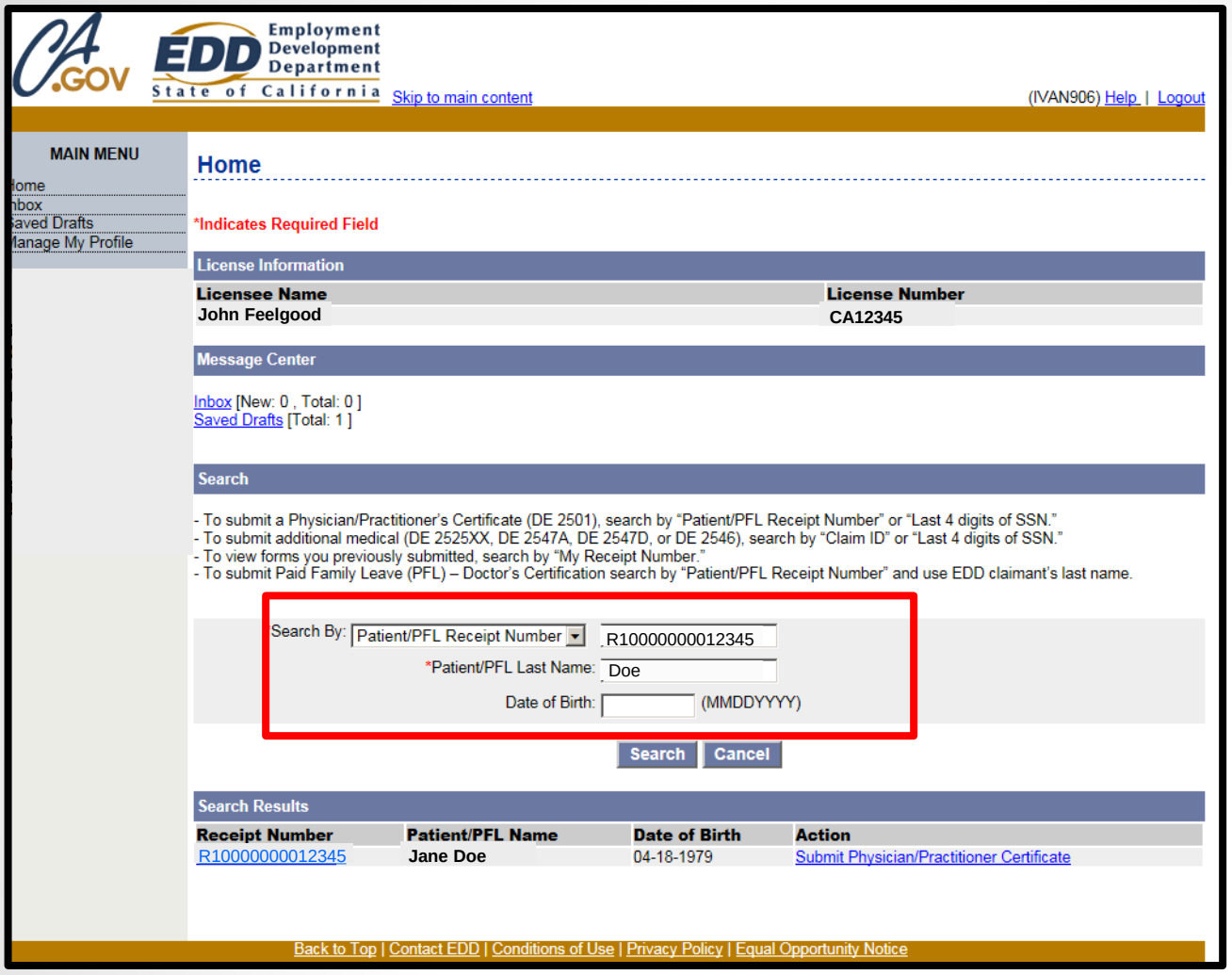
Select **Submit**. You will be directed to the **Confirmation** page and provided a Form Receipt Number.

Note: physician/practitioner representatives submitting the DE 2525XX on behalf of the physician/practitioner should select the **All Physicians** box.



On the **Confirmation** screen, select the **Form Receipt Number link** to open a PDF printer-friendly view of the information that is submitted.

Submit a DE 2501F PFL Care Claim



On the **Home** page, under the **Search** section, you may search for your patient's care provider's PFL claim:

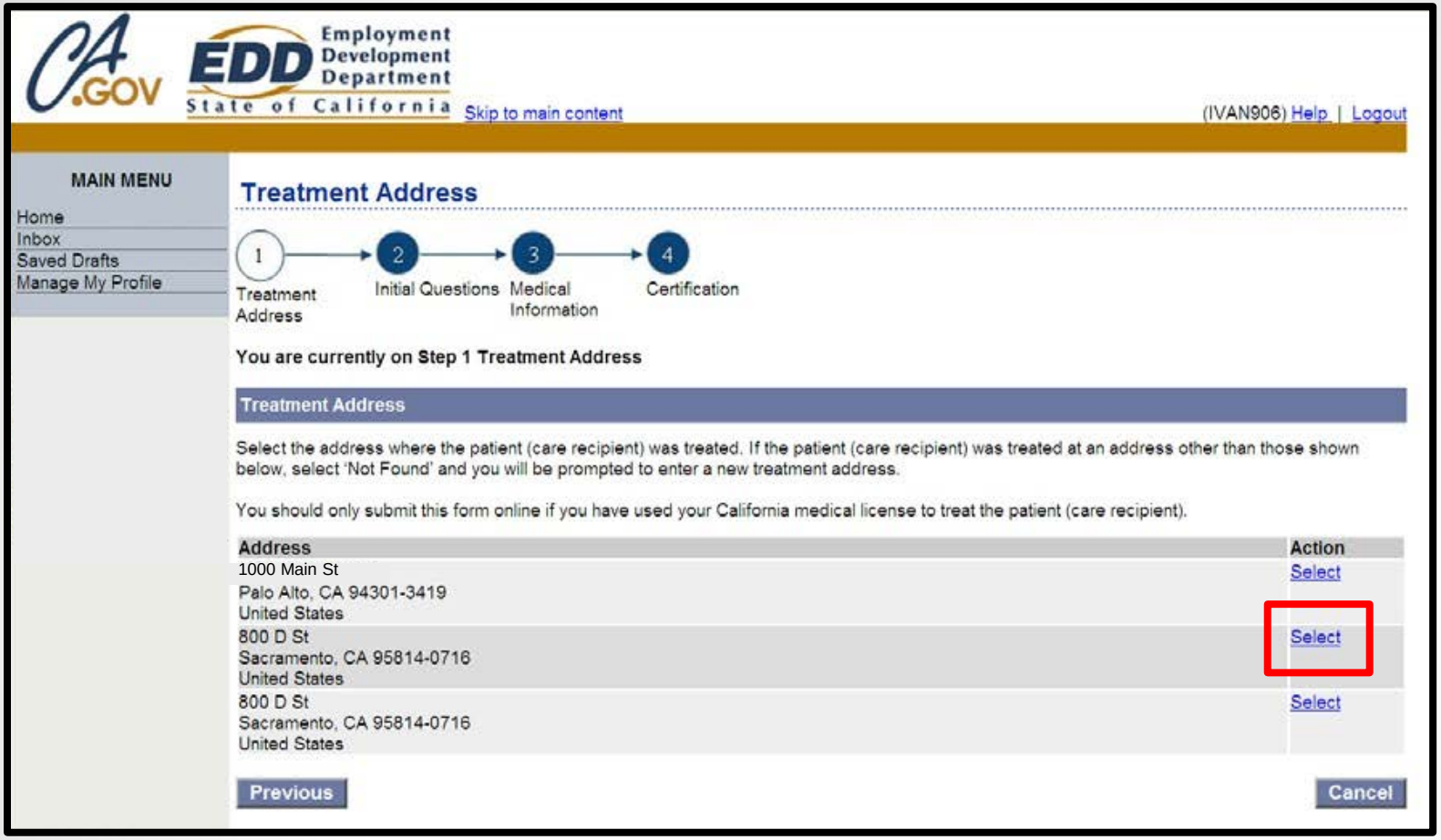
- Search by "Patient/PFL Receipt Number" to submit PFL forms for your patient's care provider.
- Search by the last four digits of the patient's SSN, Date of Birth, and Last Name.

You must also enter the patient's care provider's last name to begin the search.

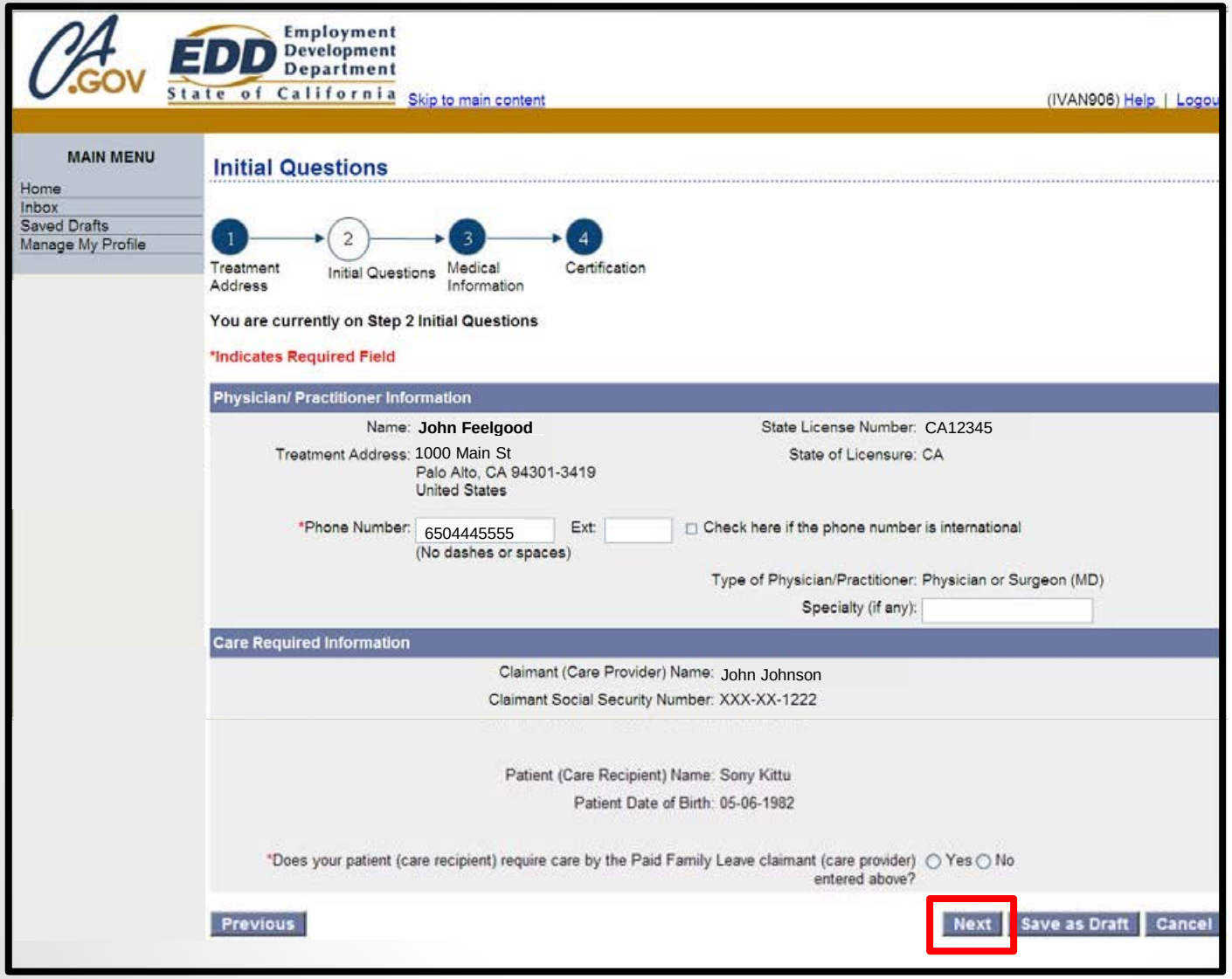
Note: In order to submit the physician/practitioner portion of the DE 2501F online, the patient's care provider must have already submitted their part of the DE 2501F.

In the **View Claimant DE 2501F** section, you may select the link to view the claimant portion of the form.

Select **Next** to complete the certificate.

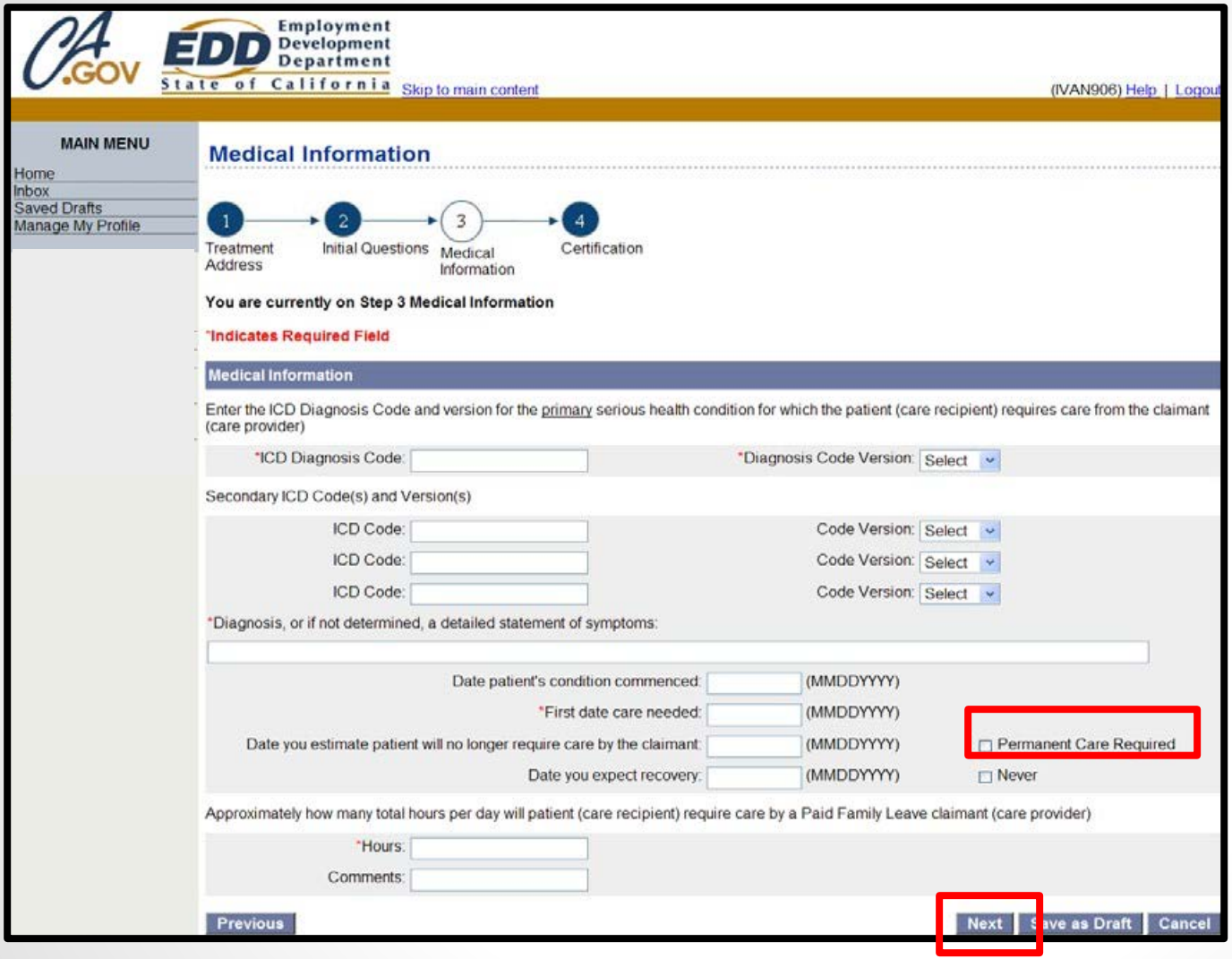


On the **Treatment Address** page, select the treatment address of where the patient is being treated.



Verify the information showing is correct and complete the **Physician/Practitioner Information** section and select **Next**.

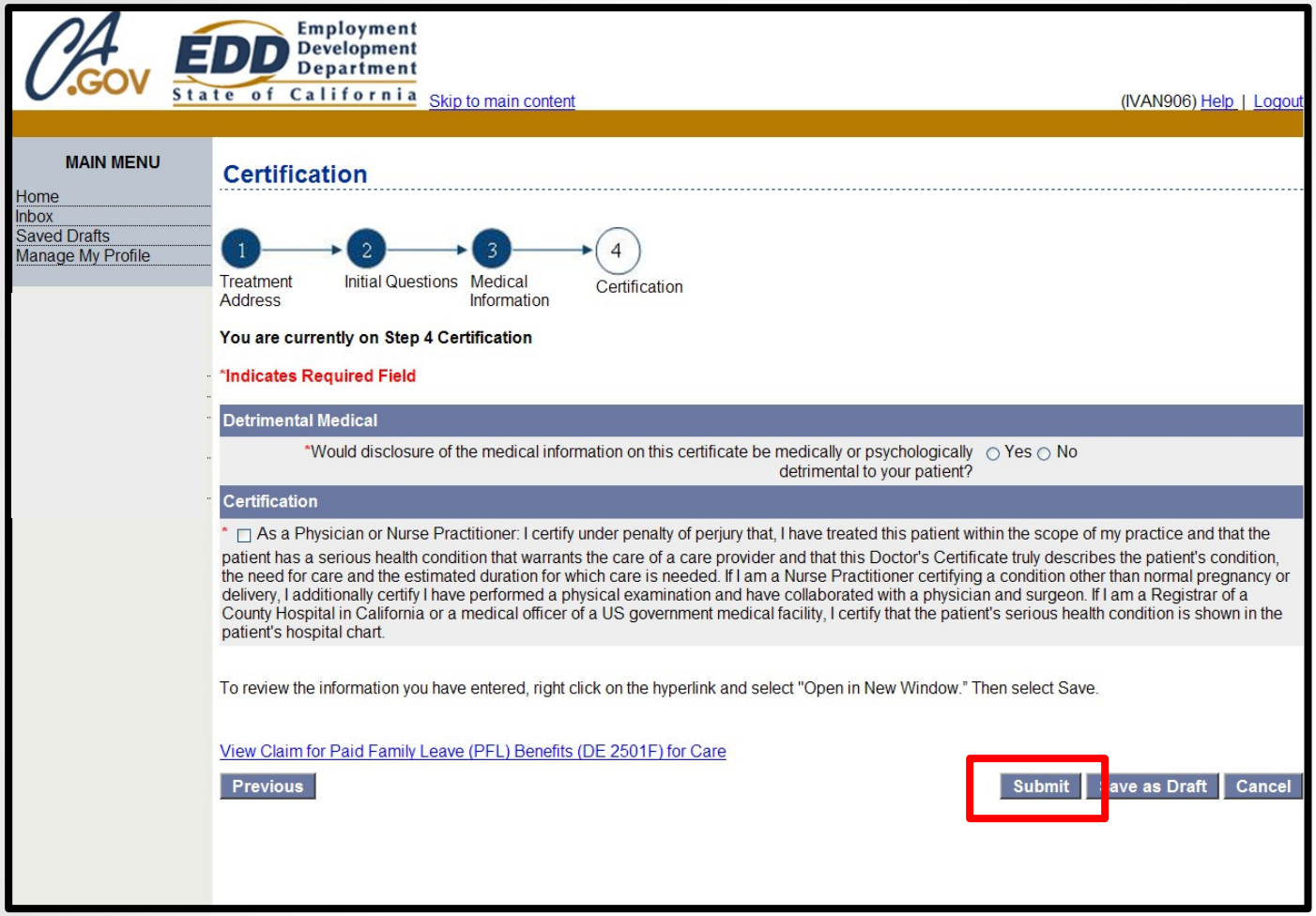
Mandatory fields are marked with a red asterisk (*).



SDI Online will accept valid ICD-9 and ICD-10 codes.

If the patient's disability is diagnosed as permanent, select the **Permanent Care Required** box.

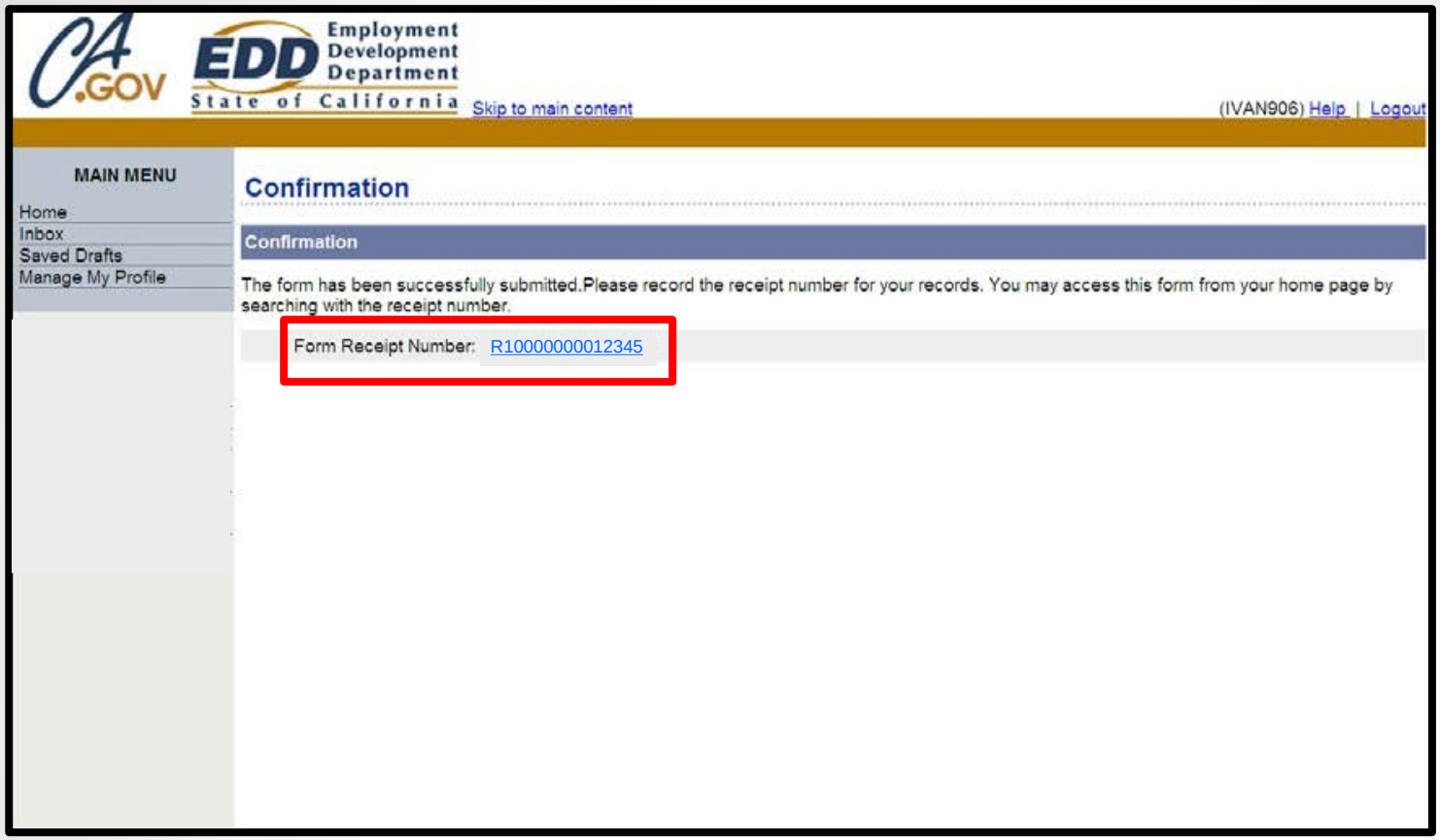
Complete all applicable fields, then select **Next**.



Once the form is completed, select the box in the **Certification** section to authorize an electronic signature.

Before submitting the form, you may view the form by selecting the link at the bottom of the page.

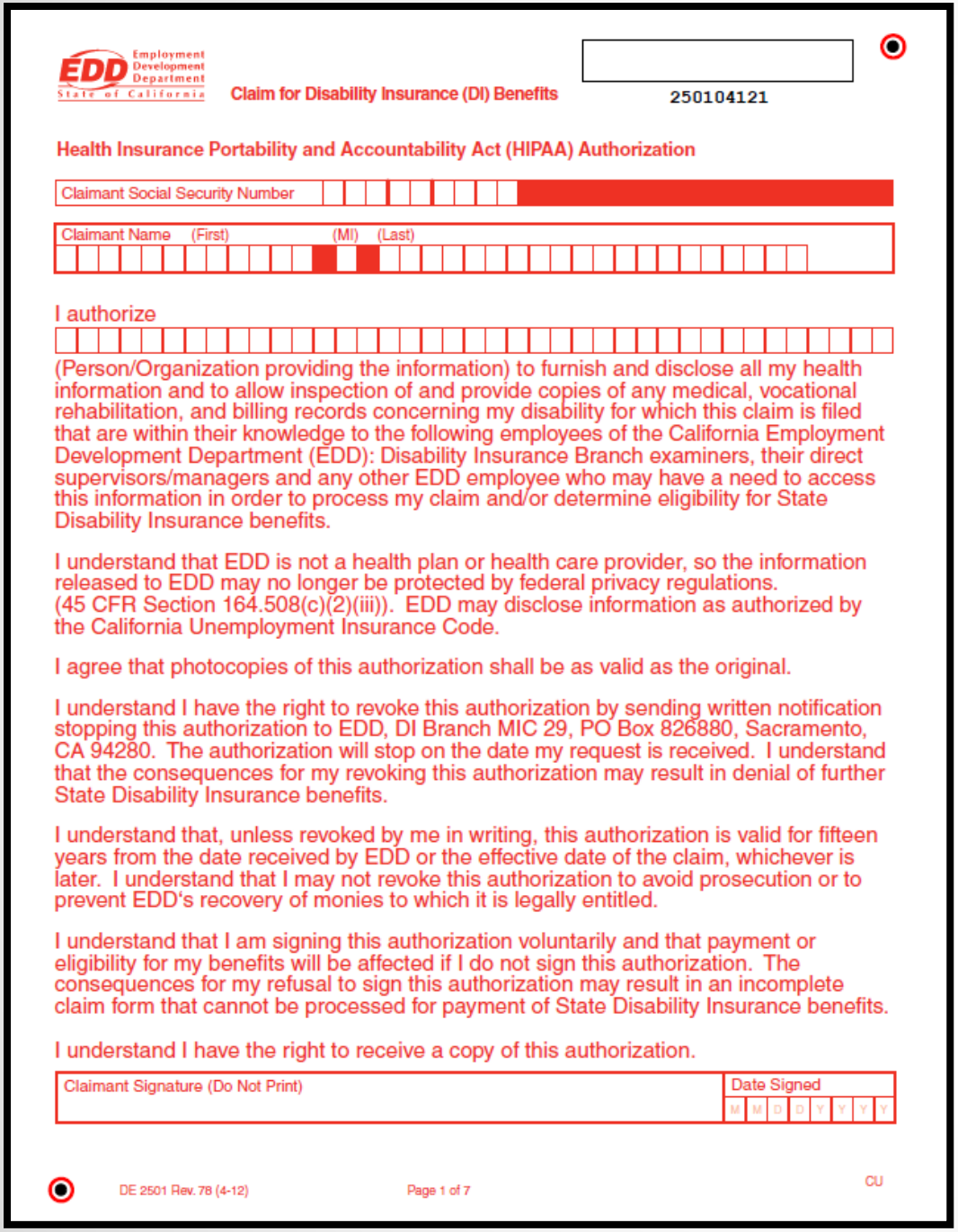
Select **Submit**. You will be directed to the **Confirmation** page and provided a Form Receipt Number.



On the **Confirmation** screen, select the **Form Receipt Number** link to open a PDF printer-friendly view of the information that is submitted.

Submit a Paper Claim Form

Disability Insurance (DE 2501)
Paid Family Leave (DE 2501F)



EDD Employment Development Department State of California

Claim for Disability Insurance (DI) Benefits

250104121

Health Insurance Portability and Accountability Act (HIPAA) Authorization

Claimant Social Security Number

Claimant Name (First) (MI) (Last)

I authorize

(Person/Organization providing the information) to furnish and disclose all my health information and to allow inspection of and provide copies of any medical, vocational rehabilitation, and billing records concerning my disability for which this claim is filed that are within their knowledge to the following employees of the California Employment Development Department (EDD): Disability Insurance Branch examiners, their direct supervisors/managers and any other EDD employee who may have a need to access this information in order to process my claim and/or determine eligibility for State Disability Insurance benefits.

I understand that EDD is not a health plan or health care provider, so the information released to EDD may no longer be protected by federal privacy regulations. (45 CFR Section 164.508(c)(2)(iii)). EDD may disclose information as authorized by the California Unemployment Insurance Code.

I agree that photocopies of this authorization shall be as valid as the original.

I understand I have the right to revoke this authorization by sending written notification stopping this authorization to EDD, DI Branch MIC 29, PO Box 826880, Sacramento, CA 94280. The authorization will stop on the date my request is received. I understand that the consequences for my revoking this authorization may result in denial of further State Disability Insurance benefits.

I understand that, unless revoked by me in writing, this authorization is valid for fifteen years from the date received by EDD or the effective date of the claim, whichever is later. I understand that I may not revoke this authorization to avoid prosecution or to prevent EDD's recovery of monies to which it is legally entitled.

I understand that I am signing this authorization voluntarily and that payment or eligibility for my benefits will be affected if I do not sign this authorization. The consequences for my refusal to sign this authorization may result in an incomplete claim form that cannot be processed for payment of State Disability Insurance benefits.

I understand I have the right to receive a copy of this authorization.

Claimant Signature (Do Not Print) | Date Signed M M D D Y Y Y Y

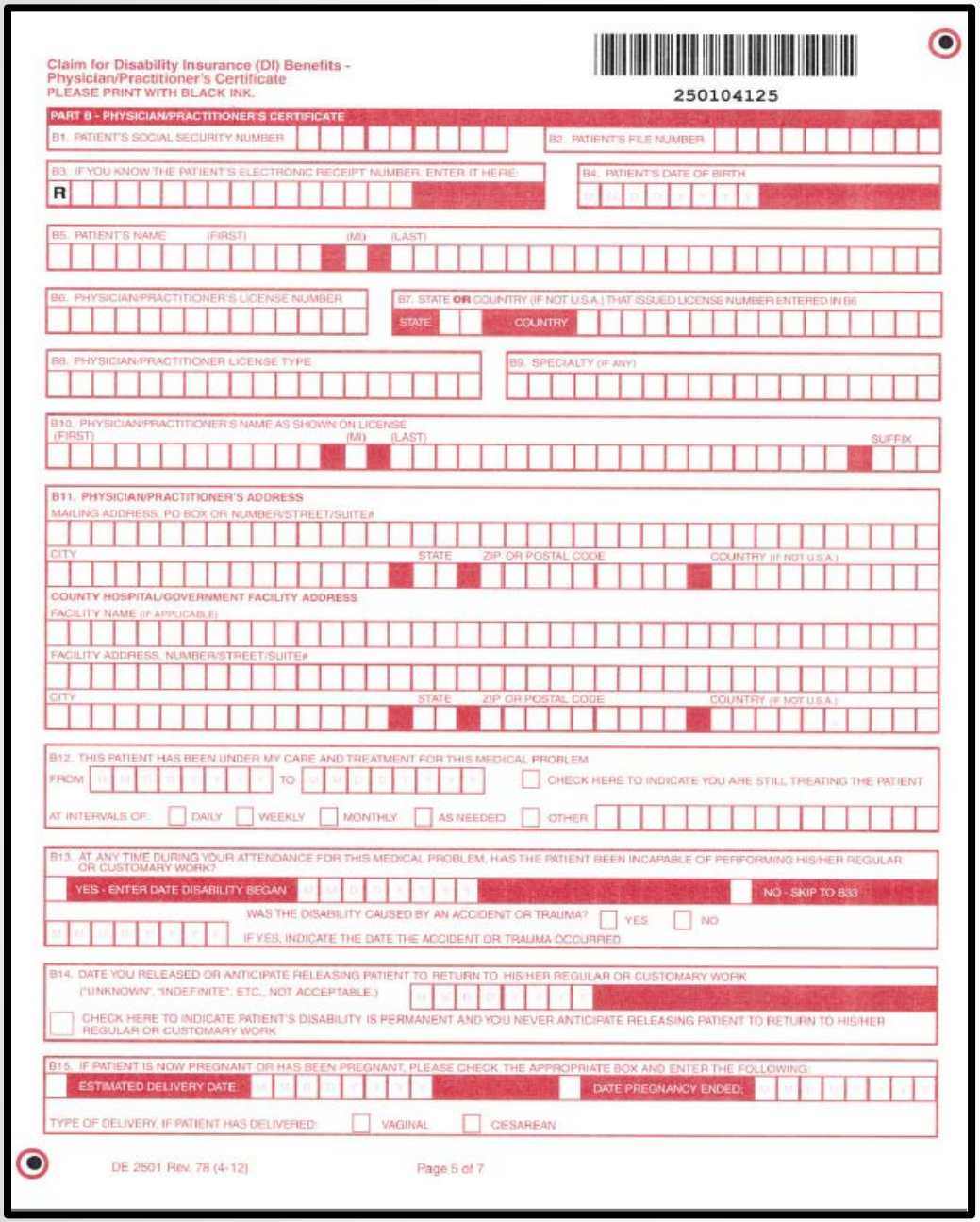
DE 2501 Rev. 78 (4-12) Page 1 of 7 CU

Claim for Disability Insurance (DI) Benefits Form, DE 2501

The Optical Character Recognition (OCR) version of paper form, DE 2501, for DI benefits is scanned and interfaces with SDI Online.

Part A pages 1-4:
Claimant's Statement

Do not photocopy or fax this form.



Claim for Disability Insurance (DI) Benefits - Physician/Practitioner's Certificate
PLEASE PRINT WITH BLACK INK.

250104125

PART B - PHYSICIAN/PRACTITIONER'S CERTIFICATE

B1. PATIENT'S SOCIAL SECURITY NUMBER

B2. PATIENT'S FILE NUMBER

B3. IF YOU KNOW THE PATIENT'S ELECTRONIC RECEIPT NUMBER, ENTER IT HERE:
R

B4. PATIENT'S DATE OF BIRTH

B5. PATIENT'S NAME (FIRST) (MI) (LAST)

B6. PHYSICIAN/PRACTITIONER'S LICENSE NUMBER

B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED IN B6
STATE COUNTRY

B8. PHYSICIAN/PRACTITIONER LICENSE TYPE

B9. SPECIALTY (IF ANY)

B10. PHYSICIAN/PRACTITIONER'S NAME AS SHOWN ON LICENSE
(FIRST) (MI) (LAST) SUFFIX

B11. PHYSICIAN/PRACTITIONER'S ADDRESS
MAILING ADDRESS, PO BOX OR NUMBER/STREET/SUITE#
CITY STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.A.)
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.)

B12. THIS PATIENT HAS BEEN UNDER MY CARE AND TREATMENT FOR THIS MEDICAL PROBLEM
FROM M M D D Y Y Y Y TO M M D D Y Y Y Y CHECK HERE TO INDICATE YOU ARE STILL TREATING THE PATIENT
AT INTERVALS OF: DAILY WEEKLY MONTHLY AS NEEDED OTHER

B13. AT ANY TIME DURING YOUR ATTENDANCE FOR THIS MEDICAL PROBLEM, HAS THE PATIENT BEEN INCAPABLE OF PERFORMING HIS/HER REGULAR OR CUSTOMARY WORK?
YES - ENTER DATE DISABILITY BEGAN M M D D Y Y Y Y NO - SKIP TO B33
WAS THE DISABILITY CAUSED BY AN ACCIDENT OR TRAUMA? YES NO
M M D D Y Y IF YES, INDICATE THE DATE THE ACCIDENT OR TRAUMA OCCURRED

B14. DATE YOU RELEASED OR ANTICIPATE RELEASING PATIENT TO RETURN TO HIS/HER REGULAR OR CUSTOMARY WORK
("UNKNOWN", "INDEFINITE", ETC., NOT ACCEPTABLE.) M M D D Y Y Y Y
CHECK HERE TO INDICATE PATIENT'S DISABILITY IS PERMANENT AND YOU NEVER ANTICIPATE RELEASING PATIENT TO RETURN TO HIS/HER REGULAR OR CUSTOMARY WORK

B15. IF PATIENT IS NOW PREGNANT OR HAS BEEN PREGNANT, PLEASE CHECK THE APPROPRIATE BOX AND ENTER THE FOLLOWING:
ESTIMATED DELIVERY DATE: M M D D Y Y Y Y DATE PREGNANCY ENDED: M M D D Y Y Y Y
TYPE OF DELIVERY, IF PATIENT HAS DELIVERED: VAGINAL CESAREAN

DE 2501 Rev. 78 (4-12) Page 5 of 7

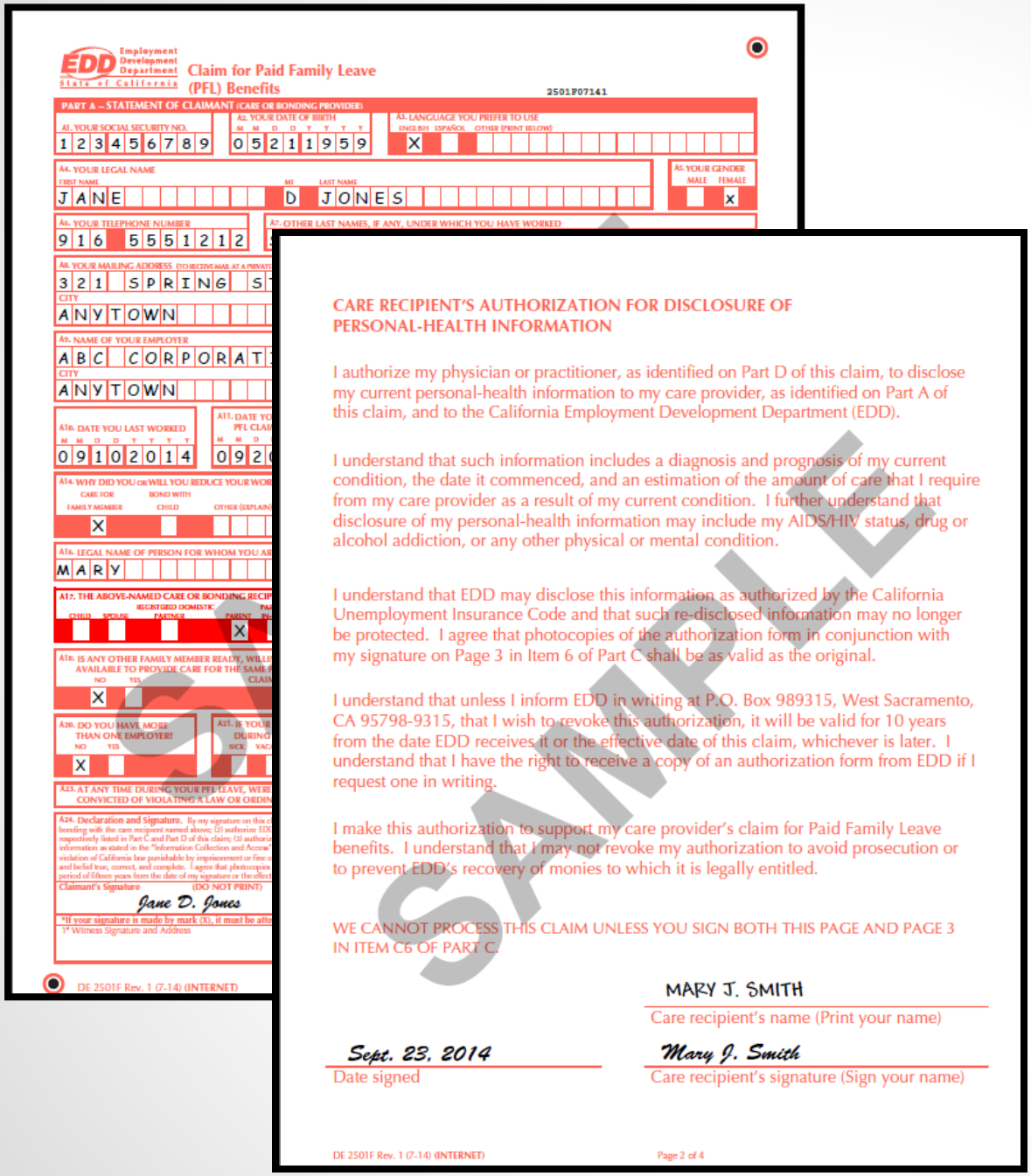
Claim for Disability Insurance (DI) Benefits Form, DE 2501

The Optical Character Recognition (OCR) version of paper form, DE 2501, for DI benefits is scanned and interfaces with SDI Online.

Part B pages 5-7: Physician's/Practitioner's Certificate

Do not photocopy or fax this form.

Claim for Paid Family Leave (PFL) Benefits, Form DE 2501F



Employment Development Department
State of California

Claim for Paid Family Leave (PFL) Benefits

2501F07141

PART A – STATEMENT OF CLAIMANT (CARE OR BONDING PROVIDER)

A1. YOUR SOCIAL SECURITY NO.: 123 45 6789

A2. YOUR DATE OF BIRTH: 05/21/1959

A3. LANGUAGE YOU PREFER TO USE: ENGLISH X

A4. YOUR LEGAL NAME: JANE D JONES

A5. YOUR GENDER: FEMALE X

A6. YOUR TELEPHONE NUMBER: 916 5551212

A7. OTHER LAST NAMES, IF ANY, UNDER WHICH YOU HAVE WORKED

A8. YOUR MAILING ADDRESS (TO RECEIVE MAIL AT A PRIVATE...): 321 SPRING ST

CITY: ANYTOWN

A9. NAME OF YOUR EMPLOYER: ABC CORPORAT

CITY: ANYTOWN

A10. DATE YOU LAST WORKED: 09/10/2014

A11. DATE YO... PFL CLAI...: 09/2...

A14. WHY DID YOU OR WILL YOU REDUCE YOUR WOR... CARE FOR FAMILY MEMBER X

A16. LEGAL NAME OF PERSON FOR WHOM YOU AR...: MARY

A17. THE ABOVE-NAMED CARE OR BONDING RECIP... PARENT X

A18. IS ANY OTHER FAMILY MEMBER READY, WILL... AVAILABLE TO PROVIDE CARE FOR THE SAME P... NO X

A20. DO YOU HAVE MORE THAN ONE EMPLOYER? NO X

A21. IF YOU'R... DURING... SICK

A23. AT ANY TIME DURING YOUR PFL LEAVE, WERE... CONVICTED OF VIOLATING A LAW OR ORDIN...

A24. Declaration and Signature. By my signature on this c... bonding with the care recipient named above; (2) authorize EDD... respectively listed in Part C and Part D of this claim; (3) authori... information as stated in the "Information Collection and Accou... violation of California law punishable by imprisonment or fine o... and belief true, correct, and complete. I agree that photocopies... period of fifteen years from the date of my signature or the effect...

Claimant's Signature (DO NOT PRINT): *Jane D. Jones*

*If your signature is made by mark (X), it must be att...

3* Witness Signature and Address

DE 2501F Rev. 1 (7-14) (INTERNET)

CARE RECIPIENT'S AUTHORIZATION FOR DISCLOSURE OF PERSONAL-HEALTH INFORMATION

I authorize my physician or practitioner, as identified on Part D of this claim, to disclose my current personal-health information to my care provider, as identified on Part A of this claim, and to the California Employment Development Department (EDD).

I understand that such information includes a diagnosis and prognosis of my current condition, the date it commenced, and an estimation of the amount of care that I require from my care provider as a result of my current condition. I further understand that disclosure of my personal-health information may include my AIDS/HIV status, drug or alcohol addiction, or any other physical or mental condition.

I understand that EDD may disclose this information as authorized by the California Unemployment Insurance Code and that such re-disclosed information may no longer be protected. I agree that photocopies of the authorization form in conjunction with my signature on Page 3 in Item 6 of Part C shall be as valid as the original.

I understand that unless I inform EDD in writing at P.O. Box 989315, West Sacramento, CA 95798-9315, that I wish to revoke this authorization, it will be valid for 10 years from the date EDD receives it or the effective date of this claim, whichever is later. I understand that I have the right to receive a copy of an authorization form from EDD if I request one in writing.

I make this authorization to support my care provider's claim for Paid Family Leave benefits. I understand that I may not revoke my authorization to avoid prosecution or to prevent EDD's recovery of monies to which it is legally entitled.

WE CANNOT PROCESS THIS CLAIM UNLESS YOU SIGN BOTH THIS PAGE AND PAGE 3 IN ITEM C6 OF PART C.

MARY J. SMITH
Care recipient's name (Print your name)

Sept. 23, 2014
Date signed

Mary J. Smith
Care recipient's signature (Sign your name)

DE 2501F Rev. 1 (7-14) (INTERNET) Page 2 of 4

SAMPLE

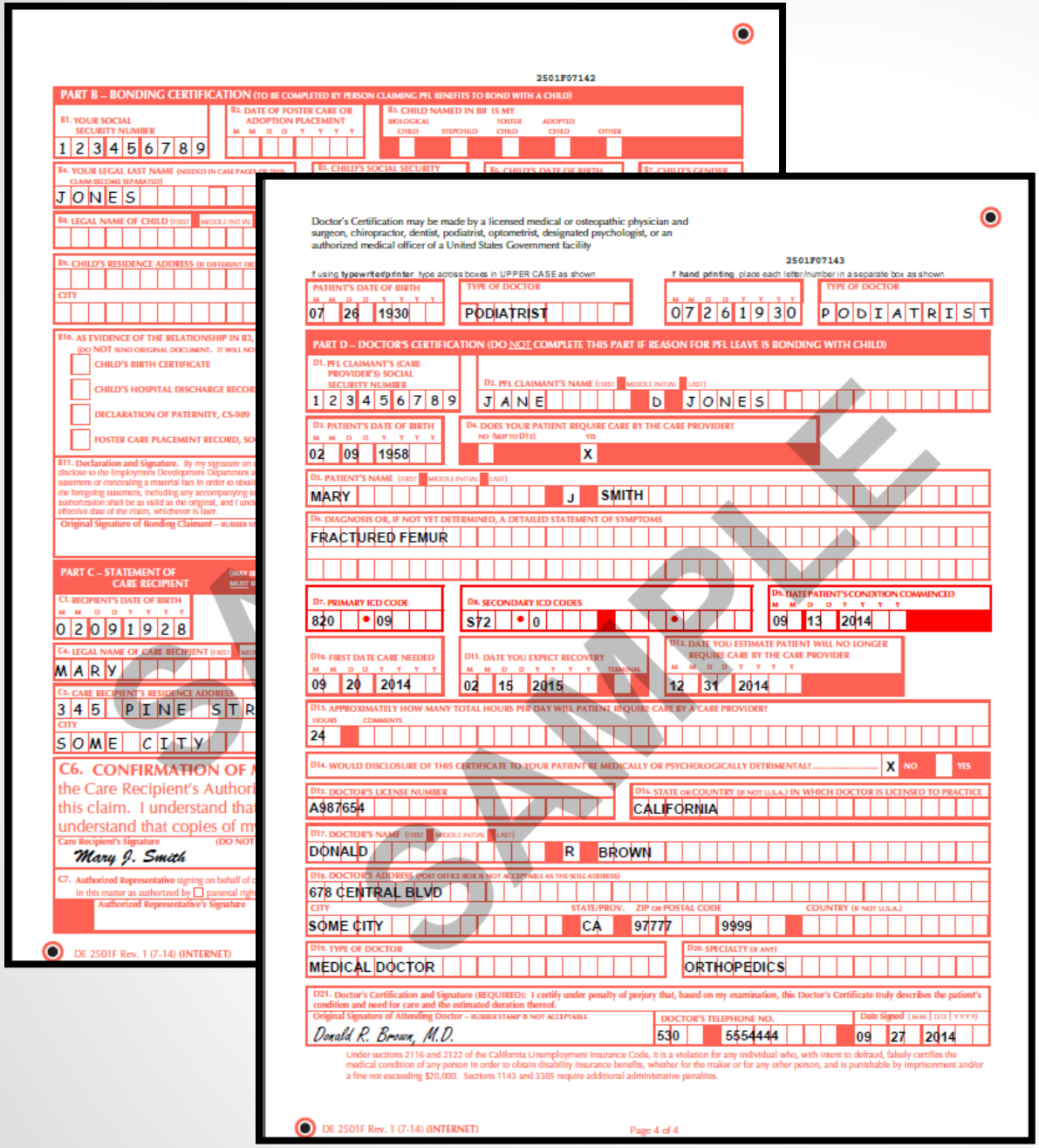
Page 1:
Claimant's Statement

Page 2:
Care Recipient's Authorization

Claim for Paid Family Leave (PFL) Benefits, Form DE 2501F

Page 3:
Bonding Certification and Statement of Care Recipient.

Page 4:
Doctor's Certification.



To avoid delays in claims processing, complete the form as follows:

- Use black ink only.
- Type or write clearly **within** the boxes provided.
- Fill out only the physician's/practitioner's portion of the form:
    - Part B for Disability Insurance (DE 2501)
    - Page D for Paid Family Leave (DE2501F)
- Provide only one medical license number. If licensed in multiple scopes of practice, use the license for the type of disability you are certifying for.
- Do not fax or photocopy the form.
- Mail the completed form to the EDD in the pre-addressed envelope provided.
- Do not mail this form to the EDD if you have already submitted this claim online.

Visit **www.edd.ca.gov/disability** for more information about State Disability Insurance.

For help with SDI Online for physicians/practitioners, call 1-855-342-3645

(please do not give this number out to patients)

The EDD is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Requests for services, aids, and/or alternate formats need to be made by calling 1-866-490-8879 (voice), or through the California Relay Service at 711.