

Licensed Health Professional and Representative Registration, Online Access, and Forms Submission

Last Updated: January 2024

Licensed health professionals can use SDI Online to:

- Complete medical certifications for disability and paid family leave benefits.
- Assign medical representatives to complete medical certifications for benefits on behalf of the licensed health professional.
 - A medical representative can create an account after the licensed health professional has added them to their SDI Online profile.
 - A licensed health professional may have an unlimited number of authorized medical representatives.
 - An individual can be an authorized medical representative for an unlimited number of licensed health professionals.
- Complete our electronic requests for additional medical information.
- Update contact information.



Steps to Register an Authorized Representative:



*The authorized medical **representative** must also complete Step 1.

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Create Your myEDD Account

Learn more about how to create your myEDD account.



Get Started

What is myEDD?

To access Employment Development Department (EDD) benefits services you must complete a one-time registration in myEDD.

myEDD uses a single login to access:

- Unemployment benefits
- Disability benefits
- Paid Family Leave benefits
- Benefit Overpayments

We offer <u>step-by-step instructions</u> on how to create a new myEDD account.

If you already created a myEDD account, you may skip to:

- <u>Register as a Physician/Practitioner in SDI Online</u>
- <u>Register as a Medical Representative in SDI Online</u>

Create Your myEDD Account

- 1. Visit <u>myEDD</u> to create your account.
- 2. Select Create Account. To view the screens in Spanish, select Español.
- 3. Enter a company email that is used only by you.
- 4. Set up a password that is 10 or more characters. The password is case sensitive and must contain:
 - Uppercase and lowercase letters
 - Numbers
 - Symbols such as !@#\$
- 5. Select your preferred language, accept our terms and conditions, and select **Submit**.

6. Next, check your email to confirm your account. Select **Confirm Email** within 48 hours or you will need to start over.

7. Login to your myEDD account. When you log in for the first time, we will email you a verification code to verify your identity. Select, **Send Email**.

Create Your myEDD Account

8. Enter the verification code and select **Submit**. This code expires in 5 minutes. If you do not receive the verification code email, check your junk or spam folder or **select resend the email**.

9. Next, set up your security question. Select a question, enter the answer, and select **Continue** to save.

10. Now you can select your Login Verification method. You can receive the verification code by text message or phone call. To continue using email, select **Use my email instead**.

11. Enter your phone number then select **Text Code** or **Call My Phone**. Then enter the verification code. This code expires in 5 minutes. A screen will let you know you have successfully set up your login verification method.

12. Select **myEDD Home**, then select **SDI Online**. On the next screen, select the SDI Online registration account type.

Use myEDD to access SDI Online and submit disability or paid family leave medical certifications.



Register as a Physician/Practitioner in SDI Online

Learn more about how licensed health professionals register in SDI Online.



Step 1: Log in

Log in to myEDD to access SDI Online, update your email, password, security question, or verification option:

- 1. Visit <u>myEDD</u>.
- Enter the email and password used to create your myEDD account.
- 3. Select Log In.





Step 2: Verify Your Identity

To protect your account, we ask you to verify your identity every time you log in. In this example, the identity verification option is by email.

Select Send Email.

If you set up the login verification option as text message or phone call, follow the instructions based on that option.

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EDD Next		
Español		
Verify Your Identity		
To protect your account, we will email you a verification code.		
Send Email		
Contact EDD Conditions of Use Privacy Policy Accessibility		
Copyright © 2023 State of California		

Step 3: Enter Verification Code

Check your email for your verification code. This code expires in five minutes. Check your spam or junk folder if you do not get this email in your inbox.

- Enter your verification code and select **Submit**.
- Select resend the email if you do not get a code.

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EDD Next								
	Español							
	Enter Verification Code							
	Enter the verification code you received					_	_	
	at {J*****@gmail.com}. This code expires in 5 minutes.	= 附 Gmail	Q Search	mail	*	0	⊛ :	: •
_	*Required Field	- Compose	← 🖬	0 i ú 0 b b :	1-16 of 16	< 1) B.	
	*Verification Code	Inbox		myEDD Verification Code			50	
		 Starred Snoozed 		California Employment Development Department to me	August 26, 2022, 3:26P	អជ៌ ។	× 1	
	Submit	 Important Sent 		Employment Development Department				+
	Didn't get the email?	Drafts 14		Hello,				
L	Check your spam folder or resend the email.	 Categories Team 	L	012345				
Contact EDD Conditions of Use Privacy Policy	Accessibility	News Work		Do not reply to this auto-generated message.				
Copyright © 2023 State of California		Personal		Thank you, Employment Development Department State of California				
		Meet						

Step 4: Select SDI Online

From the myEDD homepage, select **SDI Online** to begin your SDI Online registration.

Select Log Out in the top right corner of any screen to exit your account.

Note



Step 5: Start Registration

You are sent to the SDI Online Registration Account Type screen.

Read the instructions.

Select **Register as a Physician/Practitioner** link.



Step 6: Terms and Conditions

Next, review the terms and conditions. Select I Agree.

You must agree to these terms and conditions to create an online account.

Employment Development Department State of California	Online	By Location	By Phone
Physician/Practitio	ner: Terms and Co	onditions	
Terms and Conditions			
Please read through the entire Terms and C Do Not Agree" is selected, you will not be al	onditions before proceeding. The inforr ole to establish an online account.	nation you provide may be used to verify your i	dentity with federal and/or state agencies. If "I
These Terms and Conditions, which include th provided through this website.	e Conditions of Use and Privacy Statemer	nts, govern the use of and access to: (i) this website	e (www.edd.ca.gov/); and (ii) the information on or
If you establish an online account you are resp under your username and password. You agre other breach of security; and (ii) log out from	onsible for maintaining the confidentialit e to: (i) immediately notify the Employme your account at the end of each session.	y of your username and password, and you are re nt Development Department (EDD) of any unauth	sponsible for all activities which you authorize orized use of your username and password or any
By registering for an online account, you agree log in to your account or when you request to	e to check your account regularly and freq reset your username or password. No con	uently for messages from the EDD. Please note the fidential claim information will be sent via e-mail.	at e-mails will only be used to send notifications to
The information submitted by any party will b which may include the sharing of the information of the inform	e used by the Employment Development ion with other entities as required by law	Department to carry out its responsibilities under	the California Unemployment Insurance Code,
These Terms and Conditions may change fron	time to time and it is your responsibility	to check for updates. The last revision date for the	ese Terms and Conditions is February 1, 2012.
I have read and understand all the above info	mation and wish to continue with establi	shing an account in the State Disability Insurance	(SDI) Online.
	I Do Not Agree	IAgree	

Step 7: ID.me

We are partnered with ID.me to verify the identity of licensed health professionals.

You must verify your identity with ID.me to create an SDI Online account. Select **Verify with ID.me** to start the ID.me registration and verification process.

For help with ID.me, visit <u>California Disability Insurance and ID.me</u>.



Step 8: Allow Sharing

Once you complete the ID.me verification process, ID.me will have the option to **Allow** or **Deny** sharing your ID.me identity information with us.

If you deny sharing your ID.me information with us, you will be redirected to SDI Online and the following message will display, "You must share your identity with the EDD to create an account."

If you select deny by mistake, select Verify with ID.me to try again.

If you allow sharing your ID.me information with us, you will be redirected to SDI Online to complete the SDI Online registration.



Step 9: Enter Your Information

The system automatically fills certain information from ID.me and are read-only fields:

- Your full legal name.
- Date of birth.
- Last four digits of your Social Security number.
- National Provider Identifier or NPI number.

You must enter the following personal and professional information:

- License type, number, and expiration date.
- Medical school name and graduation year.
- Address and phone number as provided to the Department of Consumer Affairs.

You must complete the fields marked with a red asterisk (*).

Select Next to proceed.

0.cov		A Home myEDD Utilities Help LogOut
Exployment Development State of California Online	By Location	By Phone
Physician/Practitioner: Account Verific	ation Information	
*Indicates Required Field		
To register for a new SDI Online account instuide the following information		
Device of a new Sol online account, provide the following information.		
Personal Information		
First Name:	JonathanJonatha	
Last Name:	Ramakanthreddypamireddy	
*Have you used any other last names?	Ves No	
Suffix:	(If you have no suffix, leave blank.)	
E-mail Address:	SDIO_Integration_2547@SDIOT2.com	
Date of Birth:	10-15-1985	
Last four digits of Social Security Number:	XXX-XX-5555	
Physician/ Practitioner Information		
NPI Number:	5000011655	
*License Type:	Physician Assistant (PA)	
*Physician/Practitioner License Number:	PA54554544	
*License Expiration Date:	06152025	
*Medical School Name:	School	
*Medical School Year Graduated:	1985	
Address and Phone Number		
Please enter the address and phone number as provided to the Department of Consumer Affa	ers.	
*Address Line 1:	US International	
Addrass I ina 2-	acces for some broo	
Audiess Life 1.		
-city:	Rancho Corodova	
*State:	CA 🗸	
*ZIP Code:	95670	
*Phone Number:	6306306302 Ext:	: 100
	Check here if the phone number is inter	mational
Ca	ncel	Next

Step 10: Communication Preference

On the Personal Profile Information screen, select how you want to get notifications.

If you select to get notifications by email, you must log in to your account to access your messages.

Some documents are required to be sent by mail.



Step 11: Registration Complete

Be sure to save your EDD Customer Account Number (EDDCAN).

- If you selected electronic communication, a notification confirming your new account is sent to your email.
- If you selected paper communication, a letter confirming your new account is mailed to your address.

You may now log in to myEDD to access your new SDI Online account.





Access Your SDI Online Account

Learn more about how to access your online account and update personal information.



Get Started

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← → C ²	☆ ≡	Note –
0. Creov		
EDDNext		For Spanish, select
Español		
Welcome to myEDD	Log In	
myEDD connects you to unemployment,	Email	
disability, paid family leave, and benefit		
overpayment services.	Password	
	• Show	
No du 🕎 😌 🕂	Forgot password?	
	Log In	
	Don't have an account?	
	Create Account	
Contact EDD Conditions of Use Privacy Policy Accessibility		
Copyright © 2023 State of California		

Log in to myEDD to access your SDI Online account and update your email, password, security question, or verification option:

- 1. Visit <u>myEDD</u>.
- 2. Enter the email and password used to create your myEDD account.
- 3. Select Log In.

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$\leftarrow \rightarrow \mathbb{C} \bigcirc \ \triangle \not\equiv \ https://edd.ca.gov/ \qquad \qquad \diamondsuit$	≡
Ciecov	
EDDNext	
Español	
Verify Your Identity	
To protect your account, we will email	
Send Email	
Contact EDD Conditions of Use Privacy Policy Accessibility	
Copyright © 2023 State of California	

To protect your account, we ask you to verify your identity every time you log in. In this example, the identity verification option is by email.

Select Send Email.

If you set up the login verification option as text message or phone call, follow the instructions based on that option.



Check your email for your verification code. This code expires in five minutes. Check your spam or junk folder if you do not get this email.

- Enter your verification code and select **Submit**.
- Select **resend the email** if you do not get a code.



Note

Select Log Out in the top right corner of any screen to exit your account.

From the myEDD homepage, select **SDI Online** to begin your SDI Online certification.

On your SDI Online homepage, under the Search section, there are four ways to search for forms.

Search by the patient's last name and one of the following:

- The Last four digits of SSN or Patient Receipt Number and patient's date of birth.
- The Claim ID to submit additional medical.
- The My Receipt Number to review forms you have submitted.
- The Patient/PFL Receipt Number to submit Paid Family Leave forms.

Employment Development Department State of California	SDI Home	Inbox	Draft	Profile
Home *Indicates Required Field				
License Informatio	on			
Licensee Name			License Number	
John Feelgood			CA00000	
Message Center				
Inbox [New: 0 , Total: 0]				
Saved Drans (Total: 0) Search To submit a Physician/Practitions To submit additional medical (DE To view forms you previously sub To submit Paid Fam (Cave (PFL *5e)	r's Certificate (DE 2501), search by "Patient/PFL Rec 2525XX, DE 2547A, DE 2547D, or DE 2546), search by mitted, search by "My Receipt Number." - Doctor's Certification search by "Patient/PFL Hec serch By: Claim ID "Patient/PFL Last #	teipt Number" or "Last 4 digits of S y "Claim ID" or "Last 4 digits of S eipt Number" and use EDU claim T	f SSN." SN." nant's last name.	
	Date of	Birth: (MMDD/YYY)		
	Cancel	Search		

Employment				
ECCO Department Department State of California	SDI Home	Inbox	Draft	Profile
Home *Indicates Required Field				
License Informati	on			
Licensee Name			License Number	
John Feelgood			CA00000	
Message Center Inbox [New: 0, Total: 0] Saved Drafts [Total: 0]				
Search - To submit a Physician/Practition - To submit additional medical (D - To view forms you previously sul - To submit Paid Family Leave (PF	er's Certificate (DE 2501), search by "Patient/PFL Recei E 2525XX, DE 2547A, DE 2547D, or DE 2546), search by " bmitted, search by "My Receipt Number." L) – Doctor's Certification search by "Patient/PFL Recei Search By:	ipt Number" or "Last 4 digits o 'Claim ID" or "Last 4 digits of S ipt Number" and use EDD clair	of SSN." SSN." nant's last name.	

The main menu appears on most screens and has additional options.

- Inbox: Access the Message Center for messages from the EDD.
- **Draft:** Locate drafts of forms previously started, but not completed. Saved Drafts are deleted after 30 days.
- **Profile:** Update your phone number and communication preferences.

You can only update your phone number and communication preference in your SDI Online profile.

Address updates must be sent to the Medical Board with the Department of Consumer Affairs (DCA). We get this information after the DCA updates your address and we compete a license validation. Contact the DCA if you have trouble updating your address.

Go to your myEDD homepage to update your:

- Email address
- Password
- Security question
- Verification options

For instructions on adding treatment addresses, continue to the next section.





Add a Treatment Address

Learn more about how to add treatment addresses to your account.



Get Started

Employment Development Department State of California	SDI Home	Inbox	Draft	Profile	
Home *Indicates Required Field					
License Information					
Licensee Name			License Number		
John Feelgood			CA00000		
🔕 Message Center					
Inbox [New: 0 , Total: 0]					
Saved Drafts [Total: 0]					
Search					
 To submit a Physician/Practitioner's Certif To submit additional medical (DE 2525XX, To view forms you previously submitted, s To submit Paid Family Leave (PFL) – Docto 	icate (DE 2501), search by "Patient/PFL DE 2547A, DE 2547D, or DE 2546), searcl earch by "My Receipt Number." r's Certification search by "Patient/PFL I	Receipt Number" or "Last 4 digits of h by "Claim ID" or "Last 4 digits of SS Receipt Number" and use EDD claim	SSN." N." ant's last name.		

To add a treatment address, select the **Profile** link on your SDI Online homepage.

EDD Employment Development State of California SDI Home	inbox	Draft	Profile	Change:	
Physician/Practitioner Update Pers	sonal	Profile Informa	ation	Manage Treatment Address	
"Indicates Required Field	Jonat			Manage Medical Representative	
Select the Benefit Programs Online link above to update:					
Email Address Password Security Questions Personal Image/Caption					
Physician/ Practitioner Information					
Address updates must be submitted in writing to the Medical Board with the Depart validation is done.	tment of Con	sumer Affairs (DCA). DCA will provide	e EDD with your (updated address when the next license	
Licensed	e Name:	John Feelgood			
Licens	se Type:	Physician or Surgeon (MD)			
Physician/Practitioner License N	umber:	CA00000			
License Expiratio	on Date:	03-01-2020			
A	Addressi	6600 BRUCEVILLE SACARMENTO, CA 95823 United States			
Phone N	Number:	9161234567	Ext:		
		Check here if the phone number	r is international		
Medical Schoo	d Name:				
Medical School Year Gra	duated:				

From the menu:

- Hover your cursor over Change (this option is only available after selecting Profile).
- Select Manage Treatment Address from the Physician/Practitioner Update Personal Profile Information screen.
- You will be sent to the Treatment Address screen.

Employment Development Department State of California	SDI Home	Inbox	Draft	Profile	Change:
Treatment Address					
Treatment Address You may have multiple treatment addresses associated to quickly provide your address without having to read	ated with your account. The trea	atment addresses below will a	appear as selection option:	s when completing online for	ms and will allow you
No Results Found					
	Γ	Add			

Select the **Add** button to be sent to the Add Modify Treatment Address screen.

Employment Development Department State of California	SDI Home	Inbox	Draft	Profile	Change:	Complete the open fields
Add Modify Treatment A	ent Address					on the Add Modify Treatment Address
Add/Modify fredement/						screen.
		Address Line 1:				
		Address Line 2:				You must complete the
		*City:				fields marked
		*State: CA	v			with a red
		ZIP Code:				asterisk ().
	*1	Phone Number: (No	dashes or spaces) teck here if the phone nur	Ext:		Select Save .
		Cancel	Save			
						•
Note						7

If you practice at multiple locations, repeat this process to add more treatment addresses.

Employment Development Department State of California	SDI Home	Inbox	Draft	Profile	Change:			
Treatment Addres	S							
Treatment Address								
You may have multiple treatment addresses associated with your account. The treatment addresses below will appear as selection options when completing online forms and will allow you to quickly provide your address without having to re-type it.								
Address								
		Phone Number		Action				
123 Main Street Folsom, CA 95630-7325 United States		916-444-5555		Action Modify Delete				

All treatment addresses you enter are displayed on the Treatment Address screen.

- Select Modify or Delete to manage each treatment address.
- To add additional treatment addresses, select Add.

Note

Treatment addresses will appear as selection options when you or your authorized representatives complete online medical forms.



Assign a Medical Representative

Learn more about how to add your medical representatives to your account.



Get Started

Licensed health professionals may assign an unlimited number of representatives to complete and submit medical forms on their behalf.

It is the licensed health professional's responsibility to remove representatives that no longer work in their medical offices.

Employment Development Department State of California	SDI Home	Inbox	Draft	Profile	
Home *Indicates Required Field					
License Information					
Licensee Name			License Number		
John Feelgood			CA00000		
🔕 Message Center					
Inbox [New: 0 , Total: 0] Saved Drafts [Total: 0]					
Search - To submit a Physician/Practitioner's Certific - To submit additional medical (DE 2525XX, D - To view forms you previously submitted, see - To submit Paid Family Leave (PFL) – Doctor'	:ate (DE 2501), search by "Patient/PFL i IE 2547A, DE 2547D, or DE 2546), search arch by "My Receipt Number." 's Certification search by "Patient/PFL l	Receipt Number" or "Last 4 digits o 1 by "Claim ID" or "Last 4 digits of S Receipt Number" and use EDD clain	f SSN." SN." nant's last name.		

Before the medical representative can register for an SDI Online account, the licensed health professional must add the medical representative's personal information and treatment address in their SDI Online profile.

To add a physician/practitioner representative:

• Select **Profile** from the main menu.
Employment Development Department State of California	SDI Home	Inbox	Draft	Profile	Change:	
Physician/Practitione *Indicates Required Field Select the Benefit Programs Online link above to up • Email Address • Password • Security Questions • Personal Image/Caption	er Update Per	rsonal	Profile Informa	ation	Manage Irratment Orlines Manage Medical Representative	
Physician/ Practitioner Info Address updates must be submitted in writing to the validation is done.	ormation re Medical Doard with the Depar	rtment of Cons	umer Affairs (DCA), DCA will provis	de CDD with your o	updated address when the next license	
	Licens	see Name:	John Feelgood			
	Lice	inse Type:	Chiropractor (UC)			
r	I icense	Humber:	CA00000			
	Livense Expirat	Address:	123 Main St Suite 1 Anytown, CA 95814 United States			
	Phone	Number:	9161234567 Check here if the phone numb	Ext: per is international	I	
	Medical Scho	ool Name:				
	Medical School Year G	raduated:				

From the Physician/Practitioner Update Personal Profile Information screen:

- Hover over **Change** on the main menu (this option is only available after selecting **Profile**).
- Select Manage Medical Representative.

Employment Development Department State of California	SDI Home	Inbox	Draft	Profile	Change:
Add Delete Medical F	Representati	ive			
Medical Representative In	oformation				
Please select the Add button to enter a new Medic medical forms.	cal Representative. To modif	y or delete a Medical Repre	esentative, select the appr	opriate action. You are still n	esponsible for certifying the
No Results Found					
		Add			

On the Add Delete Medical Representative screen:

• Select Add.

Employment Development Department State of California	SDI Home	Inbox	Draft	Profile	Change:
Add Modify Medic	al Representa	tive			
*Indicates Required Field					
Add Representative					
		*First Name:			
		Middle Name:]
		*Last Name:			
		Suffix:			
	*Last 4 Digits of Social S	ecurity Number:			a A
		E-mail Address:			
	*Re-Type	E-mail Address:			
		*Date of Birth:	IDDYYYY)		
	*Tre:	atment Address: Sel	ect	•	
		*Account Status: Act	ive 🔻		
		Cancel	Save	1	
		Gunter	Sure		

On the Add Modify Medical Representative screen:

- Complete all open fields. You must complete the fields marked with a red asterisk (*).
- Select a treatment address.
- Select Save to add your representative.

Note

If the treatment address for your medical representative is not listed, you must select **Cancel** and add the treatment address to your profile.

Your medical representative must enter the same personal information you enter here when registering for their representative SDI Online account or they will get an error.



Change:

Add Delete Medical Representative

Medical Representative Information

Please select the Add button to enter a new Medical Representative. To modify or delete a Medical Representative, select the appropriate action. You are still responsible for certifying the medical forms.

Inbox

Name	Last 4 Digits of Social Security Number	E-mail Address	Date of Birth	Treatment Address	Account Status	Action
Jane Smith	4564	Jane@gmail.com	05-05-1985	800 d st sacramento CA 95814- 0716	Active	Modify Delete
		A	dd			

Added medical representatives are displayed on the Add Delete Medical Representative screen.

- Select **Modify** to update information for a specific medical representative.
- Select **Delete** to delete a specific medical representative.
- Select Add to add additional representatives.



Register as a Medical Representative in SDI Online

Learn more about how representatives of licensed health professionals register in SDI Online.



 e → C C A ≅ https://edd.ca.gov/ 	☆ ≡	To register for a new SDI Online account type (Claimant, employer, physician,
<section-header></section-header>	Log In Emai Password Porgot password? Log In	representative, etc.) you must first complete a one-time registration in myEDD. Use the <u>Create Your</u> <u>myEDD Account</u> section of this tutorial for instructions.
Contact EDD Conditions of Use Privacy Policy Accessibility Copyright © 2023 State of California	Don't have an account? Create Account	Note For Spanish, select Español.

Log in to myEDD to register as a physician/practitioner representative in SDI Online:

- 1. Visit <u>myEDD</u>.
- 2. Enter the email and password used to create your myEDD account.
- 3. Select Log In.

• • • • EDD × +		
← → C O A 幸 https://edd.ca.gov/	☆	≡
Ciev		
EDDNext		
Español		
Verify Your Identity		
To protect your account, we will email you a verification code.		
Send Email		
Contact EDD Conditions of Use Privacy Policy Accessibility		
Copyright © 2023 State of California		

To protect your account, we ask you to verify your identity every time you log in. In this example, the identity verification option is by email.

Select Send Email.

If you set up the login verification option as text message or phone call, follow the instructions based on that option.



Check your email for your verification code. This code expires in five minutes. Check your spam or junk folder if you do not get this email in your inbox.

- Enter your verification code and select **Submit**.
- Select resend the email if you do not get a code.



From the myEDD homepage, select **SDI Online** to begin your SDI Online registration.

SDI Online Registration

Select your account type.

Claimant

Select Register as a Claimant to:

- File a Disability Insurance (DI) or Paid Family Leave (PFL) claim.
- Access your claim information.
- View your benefit payment history.

You will need:

- Social Security number
- California driver license (CDL) or identification (ID) card

Note: If you do not have a CDL or ID, you will need to file DI by mail or file PFL by mail.

Claimant registration is available from Monday to Saturday 6 a.m. to 6 p.m. and Sunday 6 a.m. to 5:30 p.m.

Register as a Claimant

Employer

Select Register as an Employer if you represent an employer.

You will need:

- Employer Account Number (EAN)
- Employer ZIP Code (as filed with the EDD Tax Branch)
- Total Subject Wages from the most recent DE 9C

Register as an Employer

Physician/Practitioner

Select Register as a Physician/Practitioner to certify Disability Insurance (DI) or Paid Family Leave (PFL) claims for your patients.

You will need:

- Medical license information (as filed with the California Department of Consumer Affairs)
- California driver license (CDL) or identification (ID) card

Physician/practitioner registration is available from Monday to Saturday 4 a.m. to 12 midnight and Sunday 4 a.m. to 9 p.m.

Register as a Physician/Practitioner

Physician/Practitioner Representative

Select Register as a Representative if a physician/practitioner designated you as their representative to certify Disability Insurance (DI) or Paid Family Leave (PFL) claims for their patients through SDI Online.

Note: You must match the information entered by the physician/practitioner.

Register as a Representative

You will be sent to the SDI Online Registration Account Type screen.

Select the **Register as a Representative** link.

Note

You will not be able to register as a representative until the licensed health professional authorizing your account has added your information to their SDI Online profile.

Physician/Practitioner Representative: Terms and Conditions

Terms and Conditions

Please read through the entire Terms and Conditions before proceeding. The information you provide may be used to verify your identity with federal and/or state agencies. If "I Do Not Agree" is selected, you will not be able to establish an online account.

These Terms and Conditions, which include the Conditions of Use and Privacy Statements, govern the use of and access to: (i) this website (www.edd.ca.gov/); and (ii) the information on or provided through this website.

If you establish an online account you are responsible for maintaining the confidentiality of your username and password, and you are responsible for all activities which you authorize under your username and password. You agree to: (i) immediately notify the Employment Development Department (EDD) of any unauthorized use of your username and password or any other breach of security; and (ii) log out from your account at the end of each session.

By registering for an online account, you agree to check your account regularly and frequently for messages from the EDD. Please note that e-mails will only be used to send notifications to log in to your account or when you request to reset your username or password. No confidential claim information will be sent via e-mail.

The information submitted by any party will be used by the Employment Development Department to carry out its responsibilities under the California Unemployment Insurance Code, which may include the sharing of the information with other entities as required by law.

These Terms and Conditions may change from time to time and it is your responsibility to check for updates. The last revision date for these Terms and Conditions is February 1, 2012.

I have read and understand all the above information and wish to continue with establishing an account in the State Disability Insurance (SDI) Online.

I Do Not Agree

Next, review our terms and conditions.

Select I Agree.

You must agree to these terms and conditions to create an account.

Physician/Practitioner Representative: Account Verification Information					
To register for a new SDI Online account, provide the following information.					
Physician/Practitioner Representative Informatio	n				
Please enter your name as provided to the EDD by the medical provider authorizing your accour	nt.				
*First Name:					
Middle Name:	(If you have no middle name, leave blank.)				
*Last Name:					
Suffix:	(If you have no suffix, leave blank.)				
E-mail Address:	JohnSmith@gmail.com				
*Date of Birth:	(MMDDYYYY)				
*Last four digits of Social Security Number:					
Cano	rel	Next			

Enter the following personal information. You must complete the fields marked with a red asterisk (*).

- Your full legal name.
- Date of birth.
- Last four digits of your Social Security number.

If you get an error after entering your information, contact the licensed health professional authorizing your account to make sure your entries match.

Select Next.

Physician/Practitioner Representative:	Personal Profile Information	Note
*Indicates Required Field		If you select to
Physician/Practitioner Representative Information	on	get notifications by email, we
Treatment Address:	10833 Folsom Blvd Rancho Cordova, CA 95670-5000 United States	send you emails to notify you
*Phone Number:	(No dashes or spaces) Ext:	that messages
	Check here if the phone number is international	are available in
Communication Preferences		your account. However it may
Indicate below how you prefer to be notified.		be necessary to
Note: It may be necessary to send some documents via US Postal Service.		send some
*Preferred Communication:	I prefer to be notified by e-mail.	
	O I prefer to be notified by paper mail	aocuments by
	○ I do not want to receive notifications. I will be reviewing the items in my message center regularly	mail.
Can	ncel Submit	

On the Personal Profile Information screen:

• Verify the treatment address.

If an incorrect treatment address is listed, the licensed health professional authorizing your account must update the address from their SDI Online account profile.

- Enter a phone number so we can contact you during business hours, if needed.
- Select your communication preference.
- Select Submit.

SDI Online Account Registration Complete

Account Registration Successful

Your SDI Online account has been created and a notification has been sent to you via email.

Your registration is now complete.

- If you selected electronic communication, a notification confirming your new account is sent to your email.
- If you selected paper communication, a letter confirming your new account is mailed to your address.

You may now log in to myEDD to access your new SDI Online account.

	~ =	
	ш =	Note
EDDNext		For Spanish, selec
Español		Español.
Welcome to myEDD myEDD connects you to unemployment.	Log In _{Email}	
disability, paid family leave, and benefit overpayment services.	Password	
N. d. ale 3	Show Forgot password?	
	Log In	
	Create Account	
Contact EDD Conditions of Use Privacy Policy Accessibility		
Copyright © 2023 State of California		

Log in to myEDD to access SDI Online:

- 1. Visit <u>myEDD</u>.
- 2. Enter the email and password used to create your myEDD account.
- 3. Select Log In.

• • • • rso EDD × +	
$\leftarrow \rightarrow \mathbb{C} \bigcirc \ \triangle \not\equiv \ https://edd.ca.gov/ \qquad \qquad$	≡
(Gov	
EDD Next	
Español	
Verify Your Identity	
To protect your account, we will email	
you a verification code.	
Send Email	
Contact EDD Conditions of Use Privacy Policy Accessibility	
Copyright © 2023 State of California	

To protect your account, we ask you to verify your identity ever time you log in. In this example, the identity verification option is by email.

Select Send Email.

If you set up the login verification option as text message or phone call, follow the instructions based on that option.



Check your email for your verification code. This code expires in five minutes. Check your spam or junk folder if you do not get this email.

- Enter your verification code and select **Submit**.
- Select **resend the email** if you do not get a code.



From the myEDD homepage, select SDI Online.



Choose Physician/Practitioner

Physician/Practitioner Representative Choose Physician/Practitioner

You are authorized to perform work in the State Disability Insurance (SDI) Online system for the physician/practitioner(s) listed below. Please select the physician/practitioner for which you wish to perform work. You may only perform work for one physician/practitioner per log in. You will need to log out to select a different physician/practitioner.

Physician/Practitioner	New Action Required	Total Action Required	Saved Drafts
John Feelgood	19	20	0
Bob Smith	18	20	0
Jane Doe	20	20	0

If you are an authorized medical representative for multiple licensed health professionals, you have the option to choose from a list of physicians/practitioners.

Select the licensed health professional's name under the Physician/Practitioner column to complete medical certifications on behalf of that licensed health professional.

You can only complete medical certifications for one licensed health professional per log in. You must log out to select a different licensed health professional.

Home				
*Indicates Required Field				•
License Information				:
Licensee Name			License Number	
John Feelgood			CA00000	1
🐼 Message Center				l
Inbox [New: 19 , Total: 20]				
Saved Drafts [Total: 0]				
Search				
 To submit a Physician/Practitioner's Certificat To submit additional medical (DE 2525X, DE 2 To view forms you previously submitted, searc To submit Paid Family Leave (PFL) – Doctor's C 	e (DE 2501), search by "Patient/PFL Receipt Nun 2547A, DE 2547D, or DE 2546), search by "Claim l ch by "My Receipt Number." Sertification search by "Patient/PFL Receipt Nun	nber" or "Last 4 digits of SS ID" or "Last 4 digits of SSN nber" and use EDD claimar	SN." ." nt's last name.	
*Search By:	Claim ID *			
	*Patient/PFL Last Name:			
	Date of Birth:	(MMDDYYYY)		
	Cancel	Search		

You will be sent to the Physician/ Practitioner homepage.

Review the following sections of this tutorial for instructions on submitting medical forms:

- Submit a Claim for Disability Insurance (DI) Benefits (DE 2501) Part B
- <u>Submit a Physician/Practitioner's Supplementary Certificate (DE 2525XX)</u>
- Submit a Claim for Paid Family Leave (PFL) Benefits (DE 2501F) Part D



Submit a *Claim for Disability Insurance (DI) Benefits* (DE 2501) – Part B

Learn more about how to submit the DE 2501 Part B – Physician/Practitioner's Certificate





Ecop Development Department State of California	SDI Home	Inbox	Draft	Profile
Choose Physiciar	ı/Practitioner			
Physician/Practitione	er Representative Choo	se Physician/Pra	ctitioner	

You are authorized to perform work in the State Disability Insurance (SDI) Online system for the physician/practitioner(s) listed below. Please select the physician/practitioner for which you wish to perform work. You may only perform work for one physician/practitioner per log in. You will need to log out to select a different physician/practitioner.

Physician/Practitioner	New Action Required	Total Action Required	Saved Drafts
John Feelgood	19	20	0
Bob Smith	18	20	0
Jane Doe	20	20	0

The Choose Physician/Practitioner screen only displays for medical representatives completing medical certifications on behalf of a licensed health professional. Licensed health professionals should skip to the next page.

- On this screen, select the licensed health professional which you are submitting the Claim for Disability Insurance (DI) Benefits (DE 2501), Part B on behalf
- You can only select one licensed health professional at a time.
- You can switch to a different licensed health professional account by selecting **Log Out** and logging back into myEDD.

On the homepage, under the Search section, there are two ways to search for your patient's claim. Search by the patient's last name and one of the following:

- The patient's Receipt Number.
- The last four digits of the patient's Social Security number and date of birth.

To submit the Physician/Practitioner Certificate of the DE 2501 online, your patient must have already submitted Part A – Claimant's Statement of the DE 2501.

Home				
*Indicates Required Field				
License Information				
Licensee Name			License Number	
John Feelgood			CA00000	
🖾 Message Center				
Inbox [New: 19 , Total: 20]				
Saved Drafts [Total: 0]				
Search				
To submit a Physician/Practitioner's Certificate To submit additional medical (DE 2525XX, DE 25 To view forms you previously submitted, search To submit Beld Excells (actually Dented CE	(DE 2501), search by "Patient/PFL Receipt Nur 474, DE 2547D, or DE 2546), search by "Claim by "My Receipt Number."	nber" or "Last 4 digits of SSI ID" or "Last 4 digits of SSN."	N."	
To submit Paid Pamper Paid Search By:	Claim ID *		TO I GOT A GAME	
	*Datient/DEL Last Name:			
	Date of Birth:	(MMDDYYYY)		
	Cancel	Search		

Search					
 To submit a Physician/Practitioner's Certifica To submit additional medical (DE 2525XX, DE To view forms you previously submitted, sea To submit Paid Family Leave (PFL) – Doctor's 	te (DE 2501), search by "Patient 2547A, DE 2547D, or DE 2546), s rch by "My Receipt Number." Certification search by "Patient	/PFL Receipt Num earch by "Claim II /PFL Receipt Num	nber" or "Las D" or "Last 4 nber" and use	t 4 digits of SSN." digits of SSN." e EDD claimant's last name.	
*Search By:	Patient/PFL Receipt Number	r 🔽	R1000000	00033667	
	*Patient/PF	L Last Name:	Doe		
	0	Date of Birth:	(MMDDYY	YY)	
		Cancel	Sear	ch	
Search Results					
Receipt Number Patie	ent/PFL Name	Date of Birth		Action	
R10000000033667 Jar	ne Doe	01-01-1990		Submit Physician/Practitioner Certificate	

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

- The **Receipt Number** link allows you to review the information your patient submitted on the DE 2501, Part A Claimant's Statement.
- Select Submit Physician/Practitioner Certificate under the Action column to proceed.

Note

The Submit Physician/Practitioner Certificate link is not available if the certificate was submitted by another user (e.g., your representative or another doctor). Review the <u>Submit a</u> <u>Physician/Practitioner's Supplementary Certificate (DE 2525XX)</u> section to extend a disability period for your patient.

Employment Development State of California	SDI Home	Inbox	Draft	Profile
View Claimant Portion	0			
View Claimant DE 2501				
Refer to the Claim for Disability Insurance (DI) Benefit open in a new window.	ts (DE 2501) Claimant's Statemen	while completing this form. To	open the Claimant's Statement, sel	ect the hyperlink below and it will
View the Claim for Disability Insurance (DI) Benefits C	laimant (DE 2501)			
		Cancel		Next

On the View Claimant Portion screen, you can select the link to review the information your patient submitted to us.

Select **Next** to complete the medical certificate.



Department tate of California	SDI Home	inbox	Draft	Profile
Treatment Addres	SS			
1 Treatment Address	2 Patient Information	3 Claim Information).	Declaration
ou are currently on Step 1 Treatment A	ddress			
Section 2B - Treatmen elect the address where the patient was t reatment address.	nt Address reated. If the patient was treated at an addres	ss other than those shown below, sele	ct 'Not Found' and you will	be prompted to enter a new Action
Section 2B - Treatmen elect the address where the patient was t reatment address. Address 6600 BRUCEVILLE RD Sacramento, CA 95823-4671 United States	nt Address reated. If the patient was treated at an addres	ss other than those shown below, sele	ect 'Not Found' and you will	be prompted to enter a new Action Select

On the Treatment Address screen, select the address where the patient is being treated.

Note

If the patient was treated at an address other than those shown, select **Not Found**.

Important

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

	SD Haver	labor.	Doll.	Profile
Initial Questions				
Trustment Address	2 Patient Information	3 Calminformation) () ()	clanition
Yes are correctly on Step 2 Patient Informat *Indicates Required Field	les .			
Section 1 - Patient Inform	mation			
	Patiend's Name Receipt Number:	Harence larres R100000000030667		
	Secial Security Numbers Date of Girths	(MADD/WW)		
	The Namber:			
Section 2A - Physician/P	ractitioner Information			
	Name: Treatment Address:	John Feelgood 7500 Hospital Dr. Sacramento, CA 95823 United States		
	Ucense Humber:	CA00000		
	Country of Licensure:	United States		
	*Phone Mambers	(Ho dashes ar spaces)	Exti	
		Check here if the phone m	umber is international	
	Турет	Physician or Surgeon (MD)		
	Specially (Hang):			
Section 3 - Treatment In	formation			
This patient has been under my car	re and treatment for this medical problem:			
	"Frons:	(MMDD/WW)		
	Te:	(MMDDMMM)		
"Are you presently treat	ting the patient for this medical condition?	O Yes O No		
	Treatment Intervals:	Select 💌		
'Max the patient seen previously by anothe	r physician/practitioner or medical facility for the current disability/illness/injury?	Select 🔽		
	If "Yes," enter date of first treatment:	(MMDDIVYY)		
"At any time during your attendance for I incapable of perfo	this medical problem, has the patient been sming his/her regular or customary work?	O Yes O No		
Previous	Cancel	Save as braft		Next

Complete the following sections:

- Section 1 Patient
 Information
- Section 2A Physician/Practitioner Information
- Section 3 Treatment
 Information

You must complete the fields marked with a red asterisk (*).

Select Next to continue.

Note

Select **Save as Draft** at any time to complete the form later.

Tip: Selecting **No** to "Are you presently treating the patient for this medical certificate?" ends your submission and makes your patient ineligible for benefits.

EDD Separtment State of California	SDI Home	inbox	Draft	Profile
Claim Information				
Treatment Address	Patient Information	3 Claim Information	•	Declaration
You are currently on Step 3 Claim Information *Indicates Required Field	n			
Section 4A - Claim Inform	nation			
	"Date Disability Began:	(MIDDINNI)		
Indicate if the disability was caused by accid	ient or trauma; and if so, indicate the date the accident or trauma occurred below:			
	*Accident or trauma?	O Yes O No		
	Date occurred:	(MMDDYYYY)		
For non-pregnancy related claims, you must pr	rovide the following date or indicate the dis	sbility is permanent.		
Date you released or anticipate relea	asing patient to return to his/her regular o customary work	w (MMDD/WW)		
Check here to indicate patient's disabil releasing patient to re	lity is permanent and you never anticipal turn to his/her regular or customary work	te 🛄 kz		
Enter the ICD Diagnosis Code and version prevents the patient from performing	on for the <u>primary</u> disabling condition the this/her regular or customary work below	at.		
	*ICD Diagnosis Cod	e		
	*Diagnosis Code Version	Select 💌		
ICD Diagnosis Cod	de(s) for Secondary Disabling Condition(s	() a		
	ICD Diagnosis Cod	es		
	Diagnosis Code Version	Select 💟		
	ICD Diagnosis Cod	e:		
	Diagnosis Code Version	ns Select 💌		
	ICD Diagnosis Codi	e:		
	Diagnosis Code Version	Select		
*Diagnosis - If no diagnosis has been	determined, enter a detailed statement symptom	of s:		
Findings - State nature, severity, and ext	tent of the incapacitating disease or injur; include any other disabling condition	¥. 52		
Type of t	reatment/medication rendered to patien	f:		
If the patient was hospitalized, enter the da	te of entry, date of discharge and whether the patient is still hospitalized below	er #1		
	Date of entr	(MMDDIYYY)		
	Date of discharg	ez (MMDDYYYY)		

Complete Section 4A -Claim Information.

You must complete the fields marked with a red asterisk (*).

You must provide the following information:

- Date disability began.
- Estimated return to work date (this may not be required for pregnancy or permanent disabilities).
- ICD codes and version.
- Diagnosis or detailed list of symptoms.

Experiment Sector and Categories SDI Home Index	Dreft Profile
Claim Information	
Treatment Address	Claim Internation
You are currently on Step 3 Claim Information *Indicates Required Field	
Section 4A - Claim Information	
For non-pregnancy related claims, you must avoid the following date as indicate the distribution	rrrr) ištv is permanent.
Date you released or anticipate releasing patient to return to his/her regular or customary work:	(MMDDYYY)
Check here to indicate patient's disability is permanent and you never anticipate releasing patient to return to his/her regular or customary work:	
Enter the ICD Diagnosis Code and version for the primary disabling condition that prevents the patient from performing his/her regular or customary work below:	
*ICD Diagnosis Code:	
*Diagnesis Code Version:	Select
ICD Diagnosis Code(s) for Secondary Disabling Condition(s):	
ICD Diagnosis Code:	
Biagnosis Code Version:	Select 🔍
ICD Diagnosis Ceder	
Diagnosis Code Version:	Select 🕑
ICD Diagnosis Code:	
Diagnosis Code Version:	Select 💌
*Diagnosis - If no diagnosis has been determined, enter a detailed statement of symptoms:	
Findings - State nature, severity, and extent of the incapacitating disease or injury, include any other disabling conditions:	
Type of treatment/medication rendered to patient:	
If the patient was hospitalized, enter the date of entry, date of discharge and whether the patient is still hospitalized below:	
Date of entry:	(MMDDYYY)
Date of discharge:	(MMDD49999)

Section 4A Tip: Permanent Disability

If the patient's disability is diagnosed as permanent and you have selected the **permanent disability** box, you do **not** need to provide an estimated return to work date.

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

	Utes Un	10			
Check here if the patient is deceased:					
Date of death:	(MMDDYYYY)				
City:					
Country:					
State:	Select				
ter time and date of surgerularized use most secontly parformed or to be performed					
er type and date of surgery procedure most recently perior med of to be perior med below:					
Type:					
Date:	(MMDDYYYY)				
Enter the ICD Procedure Code and version for surgery/procedure(s) planned or					
performed below:					
ICD Procedure Code:					
Enter the CPT code for surgery/procedure(s) plan	Procedure Cod	e Version: ed below:	Select	>	
Enter the CPT code for surgery/procedure(s) plan	Procedure Cod	e Version: ed below: CPT Code: CPT Code: CPT Code:	Select	×	
Enter the CPT code for surgery/procedure(s) plan	Procedure Cod	e Version: ed below: CPT Code: CPT Code: CPT Code: CPT Code:	Select	Y	
Enter the CPT code for surgery/procedure(s) plans Was the patient unable to work immediately prior to th	Procedure Cod ned or perform he surgery or p	e Version: ed below: CPT Code: CPT Code: CPT Code: CPT Code: rocedure?	Select	V No	
Enter the CPT code for surgery/procedure(s) plans Was the patient unable to work immediately prior to th If "Yes," please provide the first date the patient was un	he surgery or p suble to work p	e Version: ed below: CPT Code: CPT Code: CPT Code: CPT Code: rocedure? rior to the rocedure:	Select	▼ No	
Enter the CPT code for surgery/procedure(s) plans Was the patient unable to work immediately prior to th If "Yes," please provide the first date the patient was un "Was this disabling condition caused and/or aggravated by	Procedure Cod ned or perform he surgery or p hable to work p surgery or p y the patient's custom	e Version: ed below: CPT Code: CPT Code: CPT Code: CPT Code: rocedure? rior to the rocedure: regular or ary work?	Select	 No No No 	
Enter the CPT code for surgery/procedure(s) plane Was the patient unable to work immediately prior to th If "Yes," please provide the first date the patient was un "Was this disabling condition caused and/or aggravated by "Are you completing this form for the sole purpose of referra alcoholic recovery home or drug-free facility (as indicated 2501 Claim for Disability Insurance (DI) Benefits	he surgery or p ned or perform he surgery or p surgery or p y the patient's custom il/recommenda by the patient claimant's St	e Version: ed below: CPT Code: CPT Code: CPT Code: CPT Code: rocedure? rior to the rocedure: regular or ary work? tion to an on the DE atement)?	Select	 No No No No 	
Enter the CPT code for surgery/procedure(s) plane Was the patient unable to work immediately prior to th If "Yes," please provide the first date the patient was un "Was this disabling condition caused and/or aggravated by "Are you completing this form for the sole purpose of referra alcoholic recovery home or drug-free facility (as indicated 2501 Claim for Disability Insurance (DI) Benefits Date your patient became a resident of a drug or all	he surgery or p sable to work p surgery or p y the patient's custom il/recommenda by the patient s Claimant's St icohol facility (e Version: ed below: CPT Code: CPT Code: CPT Code: CPT Code: rocedure? rior to the procedure: regular or ary work? tion to an on the DE atement)? if known):	Select	 No No No No No 	
Enter the CPT code for surgery/procedure(s) plane Was the patient unable to work immediately prior to the If "Yes," please provide the first date the patient was un "Was this disabling condition caused and/or aggravated by "Are you completing this form for the sole purpose of referra alcoholic recovery home or drug-free facility (as indicated 2501 Claim for Disability Insurance (DI) Benefits Date your patient became a resident of a drug or al "Would disclosure of the information on this form to your	he surgery or p ned or perform he surgery or p surgery or p surgery or p y the patient's custom h/recommenda by the patient i Claimant's St icohol facility (r patient be me hologically det	e Version: ed below: CPT Code: CPT Code: CPT Code: CPT Code: rocedure? rior to the rocedure: regular or ary work? wition to an on the DE atement)? if known): rimental?	Select	 No No No No No No 	

Continue completing Section 4A - Claim Information.

You must complete the fields marked with a red asterisk (*).

Tip: Providing as much information as possible prevents claim processing delays and the need for us to reach out to you for additional details.

Section 5 - Pregnancy				
Estimated belivery bate:	(MMDDYYYY)			
Pregnancy End Date (if applicable):	(MMDDYYYY)			
If this patient has not delivered and you do not anticipate releasing the patient to return to regular or customary work prior to the estimated delivery date, provide estimates for the number of days you anticipate the patient will be disabled after delivery for both of the following delivery types:				
Vaginal delivery:]
Cesarean delivery:				
If this patient has delivered, indicate type of delivery and any complications as applicable.				•
Type of delivery:	Select	~		
If pregnancy is/was abnormal, state the complication(s) causing maternal disability:				
Previous Cancel	Save as Draft		1	Next

Complete Section 5 – Pregnancy, if applicable.

Tip: Pregnancy-related disability claims

If the patient has not delivered, enter the number of days you expect the patient to be disabled postpartum for each delivery type (six weeks for vaginal delivery and eight weeks for cesarean delivery), instead of entering an estimated return to work date.

- Enter the Estimated Delivery Date.
- Enter the number 42 in the Vaginal Delivery field.
- Enter the number 56 in the Cesarean Delivery field.

Select Next.

EDD Employment Department State of California	SDI Home		Inbox	Draft	Profile	
ICD Code Summ	ary					
Treatment Address	Patient Inform	nation	3 Claim Information	4 Decla	iration	
Treatment Address	/~					
You are currently on Step 3 Claim Info	ormation					
You are currently on Step 3 Claim Info Section 4B - ICD Cod	e Summary	Version	Diagnosis		Action	

Verify the ICD codes are correct.

If an ICD code is incorrect:

- Select **Delete**.
- Re-enter the correct code in the Claim Information section.

Select Next to continue.

Employment Development Department State of California	SDI Home	Inbox	Draft	Profile		
Additional Information						
Treatment Address	Patient Information	3 Claim Information	4 Declara	tion		
You are currently on Step 3 Claim Information						
*Indicates Required Field						
Section 6 - Prognosis Information						
*What complications make your patient	disabled longer than normally expected?					
Previous	Cancel	Save as Draft		Next		

Complete Section 6 – Prognosis Information and select **Next**.

Tip: Entering as much information as possible prevents claim processing delays and the need for us to contact you for additional details.

Employment Development Department State of California	SDI Home	Inbox	Draft	Profile					
Certification									
Treatment Address	Patient Information	Claim Inform	nation	Declaration					
You are currently on Step 4 Declaration *Indicates Required Field									
Section 7 - Certification	Section 7 - Certification								
To review your information before you subm	within my scope of practice as an authorize nit, select the hyperlink below. Your informa	d physician or practitioner pur tion will display below the Clai	irsuant to California Unemploymer imant's Statement.	1 Inave performed a physical at Insurance Code Section 2708.					
View the Claim for Disability Insurance (DI) E	Benefits Physician/Practitioner Certification	(DE 2501)			-				
Previous	Cancel	Save as Draft		Submit					

Select the check box in Section 7 - Certification to confirm the information you entered.

Review the information before you submit by selecting the View the Claim for Disability Insurance (DI) Benefits Physician/Practitioner Certification (DE 2501) link.

Note: You cannot modify the form after you select Submit.

```
Select Submit.
```



On the Confirmation screen, your submission is assigned a Form Receipt Number.

- Save this Form Receipt Number. Your patient can request this number to prove the medical certificate was sent to us.
- Select the **Form Receipt Number** link to open a PDF printer-friendly version of the information you sent.

You have now completed Part B – Physician/Practitioner's Certificate of your patient's *Claim for Disability Insurance (DI) Benefits* (DE 2501) form. It can take up to 14 days to process your patient's claim.



Submit a *Physician/Practitioner's* Supplementary Certificate (DE 2525XX)

Learn more about how to submit the DE 2525XX and extend the disability period for your patient.


Employment Development Department State of California	SDI Home	Inbox	Draft	Profile					
Home *Indicates Required Field									
License Information									
Licensee Name			License Number						
John Feelgood			CA00000						
🔕 Message Center									
Inbox [New: 0 , Total: 0]									
Saved Drafts [Total: 0]									
Search - To submit a Physician/Practitioner's Certificate (DE 2501), search by "Patient/PFL Receipt Number" or "Last 4 digits of SSN." - To submit additional medical (DE 2525XX, DE 2547A, DE 2547D, or DE 2546), search by "Claim ID" or "Last 4 digits of SSN."									
- To submit Paid Family Leave (PFL) - Doctor's (Certification search by "Patient/PFL Receipt	Number" and use EDD	claimant's last name.						
*Search By:	Last 4 digits of SSN								
	*Patient/PFL Last Name	Doe							
	Date of Birth	. MMDDYYY	Y						
	Cancel	Search							

To submit a Physician/Practitioner's Supplemental Certificate from your SDI Online homepage:

- Select Claim ID or Last four digits of SSN from the Search By drop down menu.
- Enter the Claim ID or last four of the SSN for the patient.
- Enter the patient's last name.
- Enter the patient's date of birth (no dashes).

Select Search to continue.

Search										
 To submit a Physician/Pra- To submit additional medi To view forms you previou To submit Paid Family Lea 	ctitioner's Certifica cal (DE 2525XX, DE sly submitted, sear ve (PFL) – Doctor's	te (DE 2501), search by "F 2547A, DE 2547D, or DE 2 ch by "My Receipt Numbe Certification search by "F	Patient/PFL Receipt Nun 546), search by "Claim II er." Patient/PFL Receipt Nun	nber" or "Last 4 di D" or "Last 4 digit: nber" and use EDD	gits of SSN." s of SSN.") claimant's last name.				Noto	
	*Search By:	Last 4 digits of SSN	~	1303					NOLE	
		*Patie	ent/PFL Last Name:	Doe				Cla ap	ims must to)e
			Date of Birth:	MMDDYYYY				allo	W	
Claim(s) Pendi	ing Physic	ian/Practitio	Cancel	Search	501 or DE 2501F	=)		sub add me info	omission of ditional dical ormation.	
No Results Found										
Claim(s) Availa DE 2546)	able to Su	bmit Additior	nal Medical II	nformatio	on (DE 2525XX, I	DE 2547A, D	DE 2547D, or			
Claim ID	Patient/PFL N	ame d	Claim Effective Date		Action					
DI-XXXX-XXX-XXX	Jane Doe	i	11-01-2018		Submit Additional Medical In	nformation				

Verify the patient's information under the Claim(s) Available to Submit Additional Medical Information search results matches the patient's records.

- If they match, select the **Claim ID** link or the link provided in the Action column.
- If they do not match, return to the Search section, and try again.

Employment Development Department State of California	SDI Home	Inbox	Draft	Profile
Claim Summary				
Claim Summary Claimant Name: Claim Effective Date:	Jane Doe 11-01-2018		Claim ID: DI-XX	хх-ххх-ххх
My Message Center Regarding Inbox [New: 0, Total: 0] Saved Drafts [Total: 0]	Jane Doe			
My Forms Available to S Below is a list of forms available for submissi Subplices for place allows 5 7 beings of 2525XX Supplemental Medical Cert My Forms Submitted for	Submit for Jane Doe on. Please note that not all forms will be lays for the form to be processed. or Jane Doe	e available at all times. If a form fo	or the same dates has already bee	en submitted or mailed, do not submit
No Results Found				

Under the My Forms Available to Submit section:

• Select the 2525XX Supplemental Medical Cert form link.

Exployment Development Department	SDI Home	Inbox Draft	Profile						
Physician/Practitioner Supplementary Certificate (Part 1) "Indicates Required Field									
Section 1 - Physician/P	Section 1 - Physician/Practitioner Information								
Names	John Feelgood	License Number:	CA00000						
Section 2 - Patient Info	rmation								
Patient Name:	Jane Doe	Date of Birth:	MM-DD-YYYY						
Social Security Number: Claim ID:	XXX-XX-XXXX DI-XXXX-XXX-XXX	Claim Effective Date:	11-01-2018						
Section 3 - Form Inform	nation								
Please complete and submit this information Issue Date:	by the due date.	Due Date:							

The SDI Online system automatically populates certain portions of the application.

Review the following sections:

- Section 1 Physician/Practitioner Information
- Section 2 Patient Information
- Section 3 Form Information

Section 4A - Physician/Practitioner's Supplement	ary Certificate		Note
Patient File Number:			Selecting No to
Speciality, if any:			"Are you still
*Are you still treating the patient?	() Yws () №		Are you still
*Date of last treatment:	(VINDDIYYY)		
Next Appointment Date:	(MND01YYY)		patient?" ends
What present condition continues to make the patient disabled?			your submission and makes your
Enter the ICD Diagnosis Code and version for the primary disabling condition that prevents the	patient from performing his/her regular or customary work be	slow:	patient ineligible
ICD Diagnosis Code:			for further
Diagnosis Gode Version:	Select		benefits.
Enter the ICD Diagnosis Code and version for secondary disabiling condition (s) that prevents th ICD Diagnosis Code:	e patient from performing his/her regular or customary work	below:	
Diagnesis Code Versione	Select 💌		
ICD Diagnosis Code:			
Diagnosis Code Version:	Select		
ICD Diagnosis Code:			
Diagnosis Code Version:	Select 💌		
Describe how the patient's present condition/impairment prevents him/her from returning to his/her regular or customary work:			
What factors or complications are disabling the patient longer than previously estimated for this type of illness or injury?			
Cancel	Save as Draft	Next	

Complete Section 4A - Physician/Practitioner's Supplementary Certificate (Part 1).

You must complete the fields marked with a red asterisk (*).

Select Next to continue.

Employment Envelopment State of California SDI Home	Inbox	Draft	Profile	
Physician/Practitioner Supplementary	Certificate (Pa	rt 2)		
"Indicates Required Field		,		
Section 4B - Physician/Practitioner's Supplement	ntary Certificate			
"Was the patient hospitalized?	O Yea O No			
If "Yes", provide the following:				
Date of Entry:	(MNDOYNY)			
Date of Discharge:	(MNDOYYYY)			
	Check here if patient is still	hospitalized		
'Was surgery/procedure performed, or will a surgery/procedure be performed?	O Yes O No			
If "Yes", type of surgery/procedure:				
Date of surgery/procedure:	(MNDDYYYY)			
Enter the ICD Procedure Code and version for the surgery/procedure(s) planned or performer	d below:			
ICD Procedure Gode:				
Procedure Code Version:	Select 💌			
ICD Procedure Code:				
Procedure Gode Version:	Select 🛩			
ICD Procedure Code:				
Procedure Code Version:	Select 💌			
ICD Procedure Code:				
Procedure Code Version:	Select 🖌			
Enter the CPT Code for the surgery/procedure(a) planned or performed below:				
CPT Code:				
Present estimated date patient will be able to perform his/ber regular or customary	(MINDDYYYY)			
Check here to indicate patient's disability is permanent and you never anticipate releasing patient to return to his/her regular or customary work:				
"Would the disclosure of this information to your patient be medically or psychologically detrimental?	🔾 Yes 🗌 No			
Previous Cancel	Save as Draft		Next	

Complete Section 4B -Physician/Practitioner Supplementary Certificate (Part 2).

You must complete the fields marked with a red asterisk (*).

Select **Next** to continue.

Employment Development State of California	SDI Home	Inbox	Draft	Profile
Treatment Addre	SS			
Treatment Address				
Select the address where the patient was treatment address.	treated. If the patient was treated at an ad	dress other than those shown belo	w, select 'Not Found' and you wil	ll be prompted to enter a new
Address				Action
7500 Hospital Dr. Sacramento, CA 95823 United States				Select
			7	

On the Treatment Address screen:

- Select the patient's treatment address from the Action column.
- If the patient was treated at an address other than those listed, select **Not Found**.

Employment Development Department State of California	SDI Home	Inbox	Draft	Profile				
Submit Form *Indicates Required Field								
Section 5 - Certification	Submitt	ted by: John Feelgood						
Submitted by: John Feelgood I ertify 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 e amination and/or treated the patient within my scope of practice as an authorized physician or practitioner pursuant to California Unemployment Insurance Code Section 2708.								
Previous	Cancel	Save as Draft		Submit				

Select the check box in Section 5 – Certification.

Note: You cannot modify the form after you select Submit.

Select Submit to complete your form.

EDD Employment Development Department State of California	SDI Home	Inbox	Draft	Profile				
Confirmation								
Form Successfully Submit	tted							
Please print this page for your records. If a printer is unavailable at this time, please record the Form Receipt Number below. The Form Receipt Number is required to retrieve a copy of the Physiclan/Practitioner's Supplementary Certificate (DE 2525XX). You will not be able to access your confirmation page and Form Receipt Number after this window is closed.								
	Form Receipt Num	ber: R10000000035792						

On the Confirmation screen:

- Save the Form Receipt Number for your records. Your patient can request this number to prove the medical certificate was sent to us.
- Select the **Form Receipt Number** link to open a PDF printer-friendly version of the information you sent.

You have now completed the *Physician/Practitioner's Supplementary Certificate* (DE 2525XX) to extend your patient's disability benefits. Allow up to 10 days for the EDD to process this form.



Submit a *Claim for Paid Family Leave* (*PFL*) *Benefits* (DE 2501F) – Part D

Learn more about how to submit the DE 2501F Part D – Physician/Practitioner's Certification



Employment Development Department State of California	SDI Home	in	ibox	Draft	Profile
Home					
"Indicates Required Field					
License Information					
Licensee Name				License Number	
John Feelgood				CA12345	
Message Center					
Inbox [New: 0 , Total: 0]					
Saved Drafts [Total: 0]					
Search					
To submit a Physician/Practitioner's Certificat To submit additional medical (DE 2525XX, DE 2 To view forms you previously submitted, sear To submit Paid Family Leave (PFL) – Doctor's 0	e (DE 2501), search by "Patient/ 2547A, DE 2547D, or DE 2546), se ch by "My Receipt Number." Certification search by "Patient/	PFL Receipt Numl earch by "Claim ID PFL Receipt Numl	ber" or "Last 4 digi " or "Last 4 digits o ber" and use EDD o	ts of SSN." of SSN." claimant's last name.	
*Search By:	Patient/PFL Receipt Number	~	R1000000035	591	
	*Patient/PFL	Last Name:	Johnson		
	D	ate of Birth:	(MMDDYYYY)		
	c	ancel	Search		
Search Results					
Receipt Number Patien	nt/PFL Name	Date of Birth	Acti	on	
R1000000012345 John	nny Johnson	01-01-1990	Sub	nit Physician/Practitioner Certificate	

From your homepage, use the Search section to look up Part D -Physician/Practitioner's Certification of the DE 2510F form.

Search by:

- The Patient/PFL Receipt Number.
- Enter the Receipt Number (provided by the individual filing for benefits) and their last name.
- Select Search.

Note

To submit Part D of the *Claim for Paid Family Leave (PFL) Benefits* (DE 2501F) online, your patient's caregiver must have submitted Part A of the DE 2501F online.

FDD Employment						Note
State of California	SDI Home	Inbox	Draft	Profile		Select
View Claimant Porti *Indicates Required Field	on					Cancel at any time to cancel the
View Claimant DE 2501	F is NOT your patient, do not co its (DE 2501F) for Care	mplete or submit this form. To view the f	orm information submitted by you	ur patient's care provider, please		claim and return to your homepage.
Claimant (Care Provider) Name:	Sue Johnson	Claimant Socia	I Security Number: XXX-XX	-XXXX		
Patient (Care Recipient) Name:	Johnny Johnson	Pa	atient Date of Birth: 01-01-19	69		
*Do you have the patient's (care recipient's) Health Insurance Portability and Accountability Act (HIPAA) authorization to submit their medical information to EDD?	🔿 Yes 🔵 No					
		Cancel		Next]	

In the View Claimant DE 2501F section:

- Select the View Claim for Paid Family Leave (PFL) Benefits (DE 2501F) for Care link to review the claimant's section of the form.
- Select **Next** to complete the certificate.

Employment Development Department State of California	SDI Home	Inbox	Draft	Profile				
Treatment Address								
1 Treatment Address	2 Initial Questions	3 Medical Information	4 Certificat	ion				
You are currently on Step 1 Treatment Address								
Treatment Address Select the address where the patient (care recipient) was treated. If the patient (care recipient) was treated at an address other than those shown below, select 'Not Found' and you will be prompted to enter a new treatment address.								
Address				Action				
1000 Main St San Francisco, CA 94115 United States				Select				
Previous	Cancel	Not Found]					

On the Treatment Address screen:

- Select your patient's treatment address from the Action column.
- If the patient was treated at an address other than those listed, select Not Found.

Employment Development Department State of California	SDI Home	Inbox	Draft	Profile
Initial Questions				
Treatment Address	2 Initial Questions	3 Medical Information	4 Certificatio	n
You are currently on Step 2 Initial Questions				
*Indicates Required Field				
Physician/ Practitioner I	nformation			
	Name:	John Feelgood		
	State License Number:	CA12345		
	Treatment Address:	1000 Main St San Francisco, CA 94115 United States		
	State of Licensure:	СА		
	*Phone Number:	4154445555	Ext:	
		Check here if the phone numb	ver is international	
	Type of Physician/Practitioner:	Physician or Surgeon (MD)		
	Specialty (if any):			
Care Required Informat	tion			
Claimant (Care Provider) Name:	Sue Johnson	Claimant Social Security I	Number: XXX-XX-XXXX	
Patient (Care Recipient) Name:	John Johnson	Patient Date	of Birth: 01-01-1969	
*Does your patient (care recipient) require care by the Paid Family Leave claimant (care provider) entered above?	O Yes O No			
Previous	Cancel	Save as Draft		Next

The SDI Online system automatically populates certain sections of the application.

Complete the Physician/Practitioner Information section.

You must complete the fields marked with a red asterisk (*).

Select Next to proceed.

Note

Select **Save as Draft** at any time to complete the form later.

Select **Previous** to return to the previous screen.

EDD Employment Development Department	SDI Home	Inbox	Draft	Profile
Medical Informatio	n			
Treatment Address	Initial Questions	3 Medical Informatic	a 👌 (Certification
You are currently on Step 3 Medical Inform	ation			
"Indicates Required Field				
Medical Information				
Enter the ICD Diagnosis Code and version for the p	primary serious health condition for which the	patient (care recipient) requires care	from the claimant (care pro	vider)
	*ICD Diagnosis Code:			
	*Diagnosis Code Version:	Select 🔽		
Secondary ICD Code(s) and Version(s)				
	ICD Code:			
	Code Version:	Select 🔽		
	ICD Code:			
	Code Version:	Select V		
	ICD Code:			
	Code Version:	Select 🗹		
*Biagnosis, or if not determi	ned, a detailed statement of symptoms:			
	Date patient's condition commenced:	(MMDDYYYY)		
	*First date care needed:	(MMDDYYYY)		
Date you estimate patient wil	I no longer require care by the claimant:	(MIMDDYYYY)		
		Permanent Care Required		
	Date you expect recovery:	(MMDDYYYY)		
		Never		
Approximately how many total hours per day wi	ill patient (care recipient) require care by a Pai	d Family Leave claimant (care provide	r)	
	*Hours:			
	Comments			
Previous	Cancel	Save as Draft		Nett

Complete the Medical Information section.

You must provide the following information:

- Valid ICD codes.
- Diagnosis or detailed list of symptoms.
- First date care is needed.
- Estimated date care is no longer needed.
- Hours your patient will require care each day.

You must complete the fields marked with a red asterisk (*).

Select Next.

EDD Employment Development Department State of California	SDI Home	Inbox	Draft	Profile
Certification				
Treatment Address	initial Questions	Medical Information	0	Certification
You are currently on Step 4 Certification *Indicates Required Field				
Detrimental Medical				
*Would disclosure of the medical info ps	rmation on this certificate be medically or ychologically detrimental to your patient?	Ves No		
Certification				
* I certify under penalty of perjury that this patient disabilit	vatient has a serious health condition and requ y or serious health condition pursuant to Calif	uires a care provider. I have perforn ornia Unemployment Insurance Co	med a physical examinal ode Section 2708.	tion and/or treated the patient. I
To review the information you have entered, right	ght click on the hyperlink and select "Open in	New Window." Then select Save.		
View Claim for Paid Family Leave (PFL) Benefits	I (DE 2501F) for Care			
Previous	Cancel	Save as Draft		Submit

In the Certification section:

- Select the check box to confirm the information you entered.
- Select View Claim for Paid Family Leave (PFL) Benefits (DE 2501F) for Care to review the information you entered.
- **Note:** You cannot modify the form after you select Submit.
- Select Submit.

Employment Development Department State of California	SDI Home	Inbox	Draft	Profile
Confirmation				
Confirmation				
The form has been successfully submitted.Please recor	d the receipt number for your records	You may access this form from your	home page by searching with the r	eceipt number.
	Form Receipt Number:	R1000000012345		

On the Confirmation screen:

- Save the Form Receipt Number for your records. The individual filing for benefits can request this number to prove the medical certificate was submitted to us.
- Select the Form Receipt Number link to open a PDF printer-friendly version of the information you submitted.

You have now completed Part D - Physician/Practitioner's Certificate of the *Claim for Paid Family Leave (PFL) Benefits* (DE 2501F) for the caregiver's Paid Family Leave care claim. Allow up to 14 days to process this form.



Complete Paper Claim Forms

Learn more about how to complete and submit a paper claim form for disability or family leave benefits.



Common situations that require individuals to apply by paper form:

It is strongly recommended that you complete a paper *Claim for Disability Insurance (DI) Benefits* (DE 2501), Part B form when your patient applies by paper form. Submitting all forms together helps prevent errors and reduces processing time.

Patients/Claimants:

- Who are undocumented workers
- Without a valid California Driver's license or California identification card
- Name exceeds SDI Online character limitation

Health Professionals:

- Licensed out of state
- Licensed out of country
- Working in facilities
- Who are religious practitioners
- Name exceeds SDI Online character limitation

To avoid processing delays when completing a paper claim form:

Don't



Claimant Name (First) (M) (Last) Claima
Health Insurance Portability and Accountability Act (HIPAA) Authorization Claimant Social Security Number 0 0 0 0 0 0 0 0 0 Claimant Name (First) (M) Claimant Name (First) Claimant Claimant Name (First) (M) Claimant Claimant (M) (Last) Sample Claimant (M) Claimant Name (First) (M) Claimant Name (First) (M) Claimant Name (First) (Last) Sample Claimant (Last) Claimant Name (First) Claimant (Person/Organization providing the information) to furnish and disclose all my health information, and billing records concerning my disability for w
Claimant Social Security Number 0 0 0 0 0 0 0 0 0 0 0 Claimant Name (First) (MI) (Last) S a m p 1 e C 1 a i m a n t (MI) I authorize C 1 a i m a n t (MI) (Last) Geoff Booker (Booker (Booker) (First) (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.
Claimant Name (First) (M) (Last) Sample Claimant Claimant I authorize Claimant Claimant Geofff Booker Claimant (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 authorize GeofffBooker (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 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 Sample Claimant 12252015

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

The Health Insurance Portability and Accountability (HIPAA) Authorization must be completed and signed by the individual filing for disability benefits (page 1).

Part A - Claimant's Statement is completed by the individual filing for disability benefits (pages 2-4).

SAMPLE, this page for reference only
Claim for Disability Insurance (DI) Benefits - Physician/Practitioner's Certificate PLEASE PRINTWITH BLACK INK.
B3. IP YOU KNOW THE PRTIENT'S ELECTRONIC RECEIPT NUMBER, ENTER IT HERE: R 0 1 0 1 1 9 0 0
BS. PATIENT'S NAME (FINST) (M) (LAST) S a m p 1 e C 1 a i m a n t C 1 a i m a n t
Bit. PHYSICIAN/PRACTITIONER'S LICENSE NUMBER Bit. STATE OR COUNTRY (P NOT USA) THAT ISSUED LICENSE NUMBER ENTERED N BIE 6 3 4 - 0 2 7 9 3 0 STATE COUNTRY (P NOT USA) THAT ISSUED LICENSE NUMBER ENTERED N BIE
B8. PHYSICIAN/PRACTITIONER LICENSE TYPE B9. SPECIALTY ((F ANT)) M D Image: Comparison of the second secon
B10. PHYSICIANPRACTITIONER'S NAME AS SHOWN ON LICENSE (PRINST) (M) (LAST) Geofff
PACILITY NAME (# APPLCABLE) FACILITY NAME (# APPLCABLE) FACILITY ADDRESS, NUMBER/USTREET/SUITE#
CITY STATE ZP OR POSTAL COCE COUNTRY (P HOT U.S.A.)
B12 THE PATIENT HAS BEEN UNDER MY CARE AND TREATMENT FOR THIS MEDICAL PROBLEM PROM 1 2 1 6 2 0 1 5 TO U 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
B13. AF ANY TIME DURING YOUR ATTENDANCE FOR THIS MEDICAL PROBLEM, HAS THE PATIENT BEEN INCAPABLE OF PERFORMING HISHER REGULAR CIII CUSTOMARY WORK? WAS THE DISABILITY BEGAN 1 2 1 6 2 0 1 5 NO - SKIP TO 833 VMS THE DISABILITY CAUSED BY AN ACCIDENT OR TRAUMA? YES NO IF YES, INDICATE THE DATE THE ACCIDENT OR TRAUMA OCCURRED.
B14. DATE YOU RELEASED OR ANTICIPATE RELEASING PATIENT TO RETURN TO HISHER REGULAR OR CUSTOMARY WORK ('UNKNOWN', 'INDEFINITE', ETC., NOT ACCEPTABLE') III III III IIII IIIIIIIIIIIIIIIIIIII
BIS. IF PATIENT IS NOW PREGNANT OR HAS BEEN PREGNANT, PLEASE CHECK THE APPROPRIATE BOX AND ENTER THE FOLLOWING: ESTIMATED DELIVERY DATE: 01 01 02 02 02 02 02 02 02 02 02 02 02 02 02
TYPE OF DELIVERY, # INTENT HAS DELIVERED: UKGINAL CESAREAN DE 2501 Rev. 81 (3-20) (INTRANET)

Part B - Physician's/Practitioner's Certificate (pages 5-7).

As the licensed health professional, you must complete all applicable information, including:

- Care and treatment dates.
- Date disability began.
- Estimated return to work date.
- Diagnosis or a list of symptoms.
- ICD codes.
- In the case of pregnancy, the estimated delivery date and number of days for recovery per delivery type (42/56) or the pregnancy end date and delivery type.
- License and personal information.
- Your signature.

Note

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.



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

Page 1: Part A - Statement of Claimant:

The individual filing for benefits must complete all applicable information, including:

- Personal Information
- Last day worked
- Date the family leave began
- Employer information
- Signature

Part A is required for all claim types:

- Bonding
- Care
- Military Assist

PART B	BONDIN	G CERT	FICAT	ION	TOBEC	OMPLE	TED BY P	ERSON	CLAIMING PE	L BENEED	ISTO	BOND	THAC	HILDI	2					J
				82. DA	TE OF FO	OSTER	CARE OF	2	ID. CHILD	NAMED	IN BE	IS MY								
SECURI	DCIAL TY NUMBER			M M	DOPTION	N PLAC	Y Y	Y	BOLOGICAL	STERCH	10	CHL		CHILD	0	THER				
BA. YOUR LE	GAL LAST N	AME (NEED	ED IN CA	IST PACES	S OF THIS	ור	BS. CHI	LD'S SO	CIAL SECUR	ITY	1 [16. CH	LD'S D/	TE OF 8	IRTH		87. 6	CHILD	'S GB	NI
CLAIM BEC	DIME SEPARATE				ТТ	1 1	NUN	ADER OF				AS M		<u> </u>		ŕ	- î	all I	FEMAL	ì
	AME OF CH	U.D. const						_												
ID. LEGAL IN	AME OF CH	117 0 1651	albut.	No.	17517						П									Γ
m Chillip's	PERIDENCE	ADDRESS		and the								_				_		_	-	-
					TT	T					Π									
CITY			_		1 1	-	STATE/P	ROW.	ZIP OR POS	STAL COL	DE	_		COUN	NTRY (IF NOT 1	15.4.)	-	_	-
ETO. AS EVID	ENCE OF TH	HE RELATIO	INSHIP	IN B3,	CHECK	ONE O	F THE FO	DLLOWI	ING AND AT	TACH A C	OPY	OFTHE	DOCU	MENT CH	HECKE	D.				
DONO	LD'S RIGTL	CERTIFIC	ATE	WILL NOT	T GE RETUR	ENED.)				OOPTIVE	PLAC	EMENT	ACREEA	ENT AT	3.907					
H	and a maker										- Lord									
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Page 2:

Part B – Bonding Certification:

For bonding claims only. The individual filing for benefits must complete all bonding information and sign the form.

Part C – Statement of Care Recipient:

For care claims only. Your patient/care recipient or the individual filing for benefits must fill out the appropriate care information. The care recipient or their authorized representative must sign the form.

The individual filing for benefits completes either Part B or Part C – **but never both**.

Note: Part B and Part C are not needed for military assist claims.

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Page 3: Part D – Physician/Practitioner's Certification

As the licensed health professional, you must complete all applicable information for care claims, including:

- Date disability began.
- First date care was needed.
- Date you expect recovery.
- Number of hours per day care is required.
- Diagnosis or a list of symptoms.
- ICD codes.
- Your information and license.
- Signature.

Note

Part D is not needed for bonding or military assist claims.

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5: Part E – Military Certification

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Page 6: Qualifying Event for Leave Documentation

Military assist claims to meet with a third party must have supporting documentation that includes contact information for the third party and a description of the event with dates.

Individuals should make sure all pages are completed and all signatures are obtained before the claim is mailed to us for processing.

Note

The Qualifying Event for Leave Documentation is not needed for bonding or care claims.

CONTACT US 1-855-342-3645

This number is for licensed health professionals only.





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 alternate formats need to be made by calling 1-866-490-8879 (voice), or through the California Relay Service at 711.