SHORT TERM DISABILITY CLAIM FORM

Employer's Section:
Employee Name:_________________________________ Date of Birth:_______________
Social Security #:_________________________________ Date of Hire:_______________
Last Day at Work:_______________ Returned to Work:______________________

Salary:____________ ☐Monthly ☐Bi-weekly ☐Weekly Position:__________________

Employee's Section:
Address:____
Home Phone:_____________________ Sex: ☐M ☐F Last Worked:_______________
Describe symptoms of your disability:____
____
When did the disability begin?:__________________ First treatment date:__________________
Have you had the same disability before?: ☐ Yes ☐ No If yes, when?:____________________
Physician name:____________________________ Physician phone #:____________________
Is the disability related to employment?: ☐ Yes ☐ No If yes, please explain:_______________
____
Name any other employers you work for:____
Check if you are receiving income benefits from: ☐ Social Security Disability
☐ Social Security Retirement ☐Workers Compensation ☐ Veterans Association
☐Federal or State Disability ☐Any other disability payment
Please see back of this form for additional information.

Physician's Section:
Physician Name:________________________________
Phone:_____________________
Address:____
Patient first seen:___________ Frequency: ☐ PRN ☐ Weekly ☐ Monthly ☐ Other
Diagnosis:_____________________________________ ICD9
Code:_________________
Co-morbid conditions:____
Treatment (i.e.: surgery, therapy, medications, etc.):_______________________________________
____
Objective evidence of impairment:____
Describe how impairment prevents performing employment:___________________________
____
Describe how impairment prevents alternative/other employment:____________________________
____
Date patient is expected to return to work:____

I attest the above statements are true and complete to the best of my knowledge.

Physician signature:____

CLAIMANT RIGHTS AND RESPONSIBILITIES

Filing a claim: It is your responsibility to file this claim form promptly after you stop working as the result of a disability. The law requires that claims must be filed within 30 days of the beginning of the disability. The form must be fully completed by your employer, your physician and yourself. Once completed, the claim form should be submitted to:

3PAdministrators
P.O. Box 247
Onalaska, WI 54650

Appeal Rights: If you disagree with a determination on your claim and wish to appeal, you must do so in writing within 180 days after receipt of the claim denial. You will be notified of the plan's decision within 45 days. Additional information on appeal rights is included in the plan document.

Claimant Responsibilities: In addition to submitting a fully completed claim form, you are asked to sign the medical release authorization that appears below to avoid any delays in the processing of your claim. There are times when additional medical information is needed to determine the eligibility of a claim. This may include speaking with your healthcare provider and/or reviewing your medical records. You have the right to refuse to sign this authorization but such action may result in denial of your claim.

Authorization: I authorize my employer, any medical professional, hospital, medical facility, medical provider, pharmacy, government agency, insurance carrier, HMO, health plan or any Covered Entity as defined by the Health Insurance Portability and Accountability Act of 1996 to disclose to 3PAdministrators any information relating to me concerning advice, care or treatment for any health condition, including but not limited to drug or alcohol use or abuse, mental illness, HIV or other sexually transmitted diseases. I further authorize my employer, any government agency or insurance carrier/administrator to disclose any information related to my employment and all other information necessary to process my claim.

I have read and agree that the statements completed by me on the claim form are furnished in support of my claim for benefits and the information is complete, true and correctly recorded to the best of my knowledge. I understand that incorrect or untrue answers may result in denial of my claim. Any person who knowingly and with intent to defraud by presenting materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act which is a crime and subjects such person to criminal and civil penalties.

A photocopy or facsimile of this authorization shall be as valid as the original. This authorization shall be valid for one year from my signature date. I may revoke this authorization at any time in writing but such revocation will have no effect on actions taken prior to receipt of the revocation.

____ _________________________

Signature Date

____ ________________________

Printed Name Date of Birth