

UFCW Health and Welfare Fund of Northeastern Pennsylvania

DISABILITY CLAIM FORM – PHYSICIAN FORM

To be completed ONLY by the PHYSICIAN

ATTENDING PHYSICIAN: Please complete all required information and be specific. Please retain a copy for your files.

UFCW Health and Welfare Fund of Northeastern Pennsylvania

3031 B Walton Road

Plymouth Meeting, PA 19462

Phone: (610) 941-9400 Fax: (610) 941-9602

PATIENT INFORMATION

Date of Visit: ____/____/____

Patient's Name:

Patient's Address:

City:

State:

Zip:

Date of Birth: ____/____/____

Social Security No.: XXX-XX-____

Diagnosis and Concurrent Conditions (include ICD-9 Diagnosis Codes):

PREGNANCY INFORMATION

Estimated Due Date:

Complications, if any:

COMPLETION OF THIS SECTION IS REQUIRED AT INITIAL VISIT

Is condition due to injury or illness arising out of patient's employment? Yes ☐ No ☐

Please explain:

Date accident occurred or symptoms first appeared:

When did the patient first consult you for this condition?

Has the patient ever had the same or similar condition in the past? Yes ☐ No ☐

Please explain:

Does the patient have co-morbid or other conditions which are contributing to the disability? Yes ☐ No ☐

If yes, please explain:

Did the patient advise you of any other coverage (e.g., auto insurance or other disability benefit)? Yes ☐ No ☐

If yes, please explain:

REPORT OF SERVICES (or attach itemized bill)

Note: If previous form submitted to the Fund, show only dates and services since last report

Date of Service	Place of Service Use location codes	Description of Surgical or Medical Services	Procedure Code Name if other than CPT

IO – Doctor's Office

OH – Outpatient Hospital

H – Patient's Home

OL – Other Location

IH – Inpatient Hospital

NH – Nursing Home

SPU – Short Procedure Unit

Was the patient hospitalized at onset of accident or illness? Yes ☐ No ☐ Since last visit? Yes ☐ No ☐

Hospital Name:

Hospital Address:

Date of Hospitalization: From: Through:

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Patient's Name: _____ Date of Birth: ____/____/____

TREATMENT PLAN

Is the patient still under your care for this condition?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Next scheduled appointment date:					
Consult with or referral to a specialist?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
<input type="checkbox"/> Consult Only	<input type="checkbox"/> Referral/Co-Manage	<input type="checkbox"/> Transfer Care			
<input type="checkbox"/> Diagnostic Testing	<input type="checkbox"/> Physical Medicine	<input type="checkbox"/> DME or Medical Supplies	<input type="checkbox"/> Surgical Intervention		
Current Medications (include dosage and frequency):					

FUNCTIONALITY AND WORK STATUS

Patient was or will be continuously totally disabled (unable to work)?				Yes <input type="checkbox"/>	No <input type="checkbox"/>
From:		Through:			
Patient was or will be house confined?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	From:	Through:
If disabled, anticipated date to return to work (do not reply TBD or undetermined):					
Patient released to return to work?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date:	
If Yes:		<input type="checkbox"/> Without Restrictions	<input type="checkbox"/> With Restrictions		
If released <u>with</u> restrictions, list specific restrictions, limitations, hours, or graduated return-to-work schedule:					

PHYSICIAN: PLEASE READ AND SIGN BELOW:

In accordance with provisions of Internal Revenue Service Ruling 69-595, we are required to obtain your Social Security Number (Employer Identification Number in the case of associations, corporations, and other providers who are not individuals) when issuing benefits directly to you. Accordingly, please complete the section below and return this form to the address shown above. Thank you for your cooperation.

Social Security No. _____ - _____ - _____	Employer ID No. _____
Physician's Name (Print): _____	Degree: _____
Street Address: _____	City: _____ State: _____ Zip: _____
Phone No. _____	Fax No. _____

Signature (Attending Physician)

Date

THIS FORM MUST BE RETURNED TO:

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