UFCW LOCAL 1776 AND PARTICIPATING EMPLOYERS
HEALTH AND WELFARE FUND

ACCIDENT AND SICKNESS DISABILITY CLAIM 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 Local 1776 and Participating Employers Health and Welfare Fund
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 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: 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 below	**Description of Surgical or Medical Services**	**Procedure Code** Name if other than CPT

IO - Doctors 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:	**City:**	**State:**	**Zip:**
Date of Hospitalization: From:	**Thru:**		

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

TREATMENT PLAN

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

FUNCTIONALITY AND WORK STATUS

Patient was or will be continuously totally disabled (unable to work)? Yes ☐ No ☐			
From:	**Thru:**		
Patient was or will be house confined? Yes ☐ No ☐		**From:**	**Thru:**
If disabled, anticipated date to return to work (do not reply TBD or undetermined):			
Patient released to return to work? Yes ☐ No ☐		**Date:**	
If Yes,	**☐ WITHOUT RESTRICTIONS**		
	☐ WITH RESTRICTIONS		
If released with 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 I.D. No.**	
Physician's Name (Print):		**Degree:**	
Street Address:		**City:**	**State:** **Zip:**
Phone No.		**Fax No.**	

_____ _____

Signature (Attending Physician) Date

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