Short-Term Disability Form – Subsequent Statement of Claim

St. Louis – Kansas City Carpenters Regional Health Plan (Plan)
1419 Hampton Ave, St. Louis, MO 63139
Phone: (314) 644-4802 | Toll-Free: (877) 232-3863 | Fax: (314) 678-1110

CARPENTERS BENEFIT PLANS
HEALTH & RETIREMENT SERVICES

Section I – To be completed by Participant in its entirety

Name of Participant (Last)	(First)	(M.I.)	Date of Birth	Last 4 SSN

Street Address	City	State	Zip Code	Telephone

Participant/Patient is currently drawing weekly sickness and accident benefit. Updated information in order to continue this benefit is required.

Section II – To be completed by Physician

PHYSICIAN INSTRUCTIONS: The information request below is required to determine continued eligibility for weekly accident and sickness benefits. Please complete this section in its entirety. **Total Disability** under the terms of the Plan means the patient is prevented from engaging in any or all of his/her occupation for compensation.

SPECIFIC DATES OF TOTAL DISABILITY - **FROM:**_____ **THROUGH:** _____

ICD-10 CODE **DIAGNOSIS OR NATURE OF ILLNESS OR INJURY**

1. _____
2. _____

Date Patient able to return to work (MM/DD/YY): _____ **Was the Patient admitted to the Hospital?** ☐ Yes ☐ No

If yes, list date of confinement, name and address of facility: _____

_____

Was surgery performed? ☐ Yes ☐ No If so, date of surgery: _____ Name of referring physician: _____

Signature & Degree of Physician	Date	Federal EIN/SSN	Print – Physician Name, Address & Phone