Short-Term Disability Form

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

Reset form

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

Disability Type: ☐ Illness ☐ Accident Date Treatment first Sought for Illness or date Accident occurred: _____

Were you employed when your initial disability occurred? ☐ Yes ☐ No

If yes, Name and Phone Number of Employer: _____

Are you receiving or eligible for any compensation or short-term disability benefits from your employer? ☐ Yes ☐ No

Describe Illness or Injury (if resulting from an accident, explain where and how accident occurred. If pregnancy, give due date):

_____

_____

Was this disability caused by a Third Party? ☐ Yes ☐ No
Was this disability by a result of your employment? ☐ Yes ☐ No
If so, has a Workers' Compensation Claim been filed? ☐ Yes ☐ No

Authorization by Participant
I hereby authorize the use and disclosure of my individually identifiable health information as described above. I understand this authorization is voluntary and revocable at any time. I understand if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Participant Signature: _____ Date: _____

Verification by Participant
I certify the above statements and answers are true and complete to the best of my knowledge and belief. I hereby agree to reimburse Carpenters Health Plan to the extent of the amounts paid in the event benefits are paid or payable under any Worker's Compensation Law or similar legislature, or under the subrogation provisions related to a third-party liability. I hereby authorize any licensed physician or dentist, medical or dental practice, clinic, hospital, or other medical or dental related facility, insurance company, or other person, organization, or institution that has any record of me or any of my dependents, to give Carpenters Health Plan, or its representative any such information for the administration of claims. A photocopy of this authorization shall be as valid as the original authorization.

Participant Signature: _____ Date: _____

Direct Deposit Information: Bank Routing Number: _____ **Bank Account Number:** _____

Section II – To be completed by Physician

PHYSICIAN INSTRUCTIONS: The information request below is required to determine continued eligibility for short-term disability 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.

Disability Type: ☐ Injury ☐ Illness
Date Patient first consulted you for this condition: _____
Has the Patient ever had similar symptoms? ☐ Yes ☐ No
Is the condition related to the Patient's employment? ☐ Yes ☐ No
Is the condition related to a motor vehicle accident or other non-occupational accident? ☐ Yes ☐ No

ICD-10 Code Diagnosis or Nature of Illness or Injury
1. _____
2. _____

Specific Dates of Total Disability From: _____ **Through:** _____

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