PATIENT DISABILITY / INSURANCE CLAIM FORM

Please allow a maximum of 2 weeks for forms to be completed

$20 fee PER form MUST be paid prior to release of completed forms

Please complete **your** portion of the claim form / disability form before giving it to us.

Please complete the below information and attach this to your form along with payment and return to The Women's Healthcare Group.
Please complete each item below, leaving items blank may delay us from being able to complete your form(s) in a timely manner.

Today's Date: ______________________________Doctor/Midwife__________________________________

Patient Name: ____ Patient Date Of Birth: ________________

Name of FMLA/Disability Company to Release Information to: ____

Reason for claim form / disability form completion:

- ☐ Pregnancy Leave and/or Recovery
- ☐ Surgery Leave and/or Recovery
- ☐ Spousal Leave
- ☐ Other: ________________________________

1. When is first planned day of leave? ____
2. What is the planned return date? ____
3. Will you return from leave on "regular" duties? ____
4. If not returning on "regular" duty what type of restrictions will you have? ______________________________
5. Daytime phone where you can be reached (if we have questions)? _____________________________________
6. When we complete this form what would you like us to do?
   - ☐ Call me to pick up in 2 weeks after form completion.____
   - ☐ Mail to: ____
   - ☐ Fax to: ____

Additional Comments (if needed): ____

I understand that the records to be used or disclosed pursuant to this authorization may contain certain records relating to participation in Federally assisted drug and alcohol abuse programs; information relating to diagnosis and treatment of mental health (such as depression), alcoholic or drug counseling session provided such notes are maintained separately; information relating to HIV testing, HIV status, or AIDS. I understand that such information is subject to special protections pursuant to 45 C.F.R. 164.508; 42 C.F.R. Part 2; K.S.A. 65-5601 et seq.; and K.S.A. 65-6001 et seq. By my signature below I authorize the use or disclosure of records containing such information if they are otherwise included within the scope of this authorization. ***THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE ONE YEAR FROM THE DATE OF SIGNATURE***At this time, I understand that this authorization may be revoked in writing by me at any time, except to the extent that this action has been taken. I understand that any release which was made prior to my revocation in compliance with this authorization shall not constitute a breech of my rights to confidentiality. I also understand that if the requester or receiver of my medical records is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and my be re-disclosed.

Signature of Patient or Legal Guardian ____ Date ________________

Relationship if not the Patient ____

Signature of Witness ____ Date ________________

- For Office Use Only –

Number of Forms Completed _____ x $20.00 each = ____________Total Due prior to Form Release

Payment Received ____/_____/____ by __________________ posted by _______________

Nurse Completion ____/_____/____ by___________

Provider Signature ____/_____/____

Sent by (Circle) FAX, MAIL, OR PICKUP ____/_____/____ by__________

Scanned ____/_____/____ by__________