Weekly Disability Claim Form

Clear Form

Employer Name: _____ **Group Number:** _____

Please Print or Type When Completing This Form

Section 1: Employee Information

Employee Last Name	First Name	MI	HPI Member ID#	Date of Birth

Mailing Address	City	ST	ZIP Code

Social Security Number	Primary Phone#	Email Address	Occupation

Is this claim due to an accident or illness?		Date of accident or onset of illness:		Location (address if known) of accident or onset of illness:	

Were you working for your employer at the time of the injury or onset of illness?	Was the injury or onset of illness related to your employment duties?	Have you filed a Worker's Compensation claim for this condition?

Please describe how the injury or onset of illness occurred

The above statements are true and correct to the best of my knowledge and understanding. I hereby authorize any hospital, physician or any other organization, institution, company, governmental agency or person who has examined or attended to me, or who has my records or knowledge of me or my health, to furnish to Health Plans, Inc. and its authorized representatives any and all information with respect to any illness or injury, medical history, consultation, prescriptions, treatment or benefits, and copies of all hospital records or any other documentation related to this claim. I also agree a photocopy of this authorization shall be as valid as the original.

Employee Signature: _____ **Date Signed:** _____

Section 2: Attending Physician's Information and Statement

Physician's Full Name	Physician's Phone#

Physician's Address	City	ST	ZIP Code

Patient's Diagnosis (ICD-10 Code)	Patient's Current Condition(s)

Date injury or onset of illness occurred	Date of hospitalization	Date patient first consulted you	Is the patient pregnant?	If yes, expected date of delivery
	☐ n/a			

Is the patient totally disabled from performing his/her job?	Dates of continuous total disability
	From through

Is the patient totally disabled from performing his/her job?	Is the patient currently under your care due to this condition?	Date of next appointment:
		☐ n/a

Physician Signature: _____ **Date Signed:** _____

Section 3: To Be Completed by Employer

Policy#	Date Last Worked	Date Returned to Work	Weekly Earnings	# Hours/Week

Has a Worker's Compensation claim been filed?	If not, will a Worker's Compensation claim be filed?

Employer's Representative Name (please print)	Title	Phone#

Signature of Employee Representative: _____ **Date Signed:** _____