DISABILITY, FMLA & Paid Family Leave QUESTIONNAIRE Allow 5 Days for processing

An <u>AUTHORIZATION FOR USE AND DISCLOSURE OF MEMBER/PATIENT HEALTH</u> **INFORMATION** must be attached

In order to process your claim: please **COMPLETE ALL** the information below.

Step1: Check all that apply: State Disability Private Disability FMLA	Paid Family Leave (PFL)
 Step 2: Member/Patient must provide a Visit Verification of Treatment (VOT) from the treating physician for dates of disability. Claim may be delayed if VOT is not available. A new VOT is required for extensions and should have a new return to work date. 	
Do you have a VOT from the treating Physician? Yes No	
Patient Name: Medical Record Num	ber:
Phone Number:	
Name of Treating Physician:	
What is the specific condition?	
If Pregnancy: Due date Delivery date Type: \[\begin{align*} \text{No} \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	rmal
Step 3: State or Private Disability	
First Date unable to Work:Estimated or Actual Return to work date:	
Step 4: Family Medical Leave Act (FMLA)	
Do you agree for Kaiser to provide medical facts or specific condition information at the request of your employer? Yes No Initials	
Is the FMLA to care for a Family member other than yourself?	
If Yes, provide your name and relationship to the patient	
Dates of FMLA: Starting: / / To: / /	
Is FMLA for a block of time? ☐ Yes ☐ No	
If FMLA is for an ongoing CHRONIC CONDITION requiring INTERMITTENT TIME OFF: How many episodes per month? How many hours or days off per month?	
Step 5: Paid Family Leave (PFL): For Care of a Family Member How many hours per day is required to care for the Family Member?	
Dates of Care: Start: / / End Date of Care: / /	