MERITAIN HEALTH
An Aetna Company

# Short-Term Disability Claim Form
## Employee Form

*ALL questions must be answered to avoid a possible delay. Please return completed form to employer. Claims are subject to review to determine medical appropriateness.*

## Employee's Statement of Claim — *Please Print*

| Full Name | Social Security Number | Phone Number | |
|---|---|---|---|
| Mailing Address (if different from street address) | City | State | Zip Code |
| Employer Name | Email address (optional) | | |
| Date of Birth: | Marital Status: ☐ Single ☐Married ☐ Widowed ☐ Divorced | Gender: ☐ Male ☐ Female | |
| Is the claim a result of a work related illness or injury? ☒Yes ☒ No | Is claim due to an accident/injury? ☒ Yes ☒ No | | |
| Have you or will you file a claim for workers compensation benefits? ☐ Yes ☐ No | Please provide a detailed description of how injury occurred and location. | | |
| Date Disability commenced | Date disability ceased | | |
| Have you filed for Social Security Benefits? ☐ Yes ☐ No | Date that claim was filed: | Date that Social Security benefits commenced: | |
| **Important notice to all employees: Time spent on short-term disability leaves of absence (including any waiting periods) will be deducted from your 12-week leave bank in accordance with the Family Medical Leave Act of 1993** **Employee initials** | **Any person who knowingly and with intent to defraud any insurance company or claims administrator or other person files an application for insurance or statement of claim, containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.** **Employee initials** | | |

## Attending Physician's Statement — *Please Print*

| Diagnosis | ICD9 Code | Disability due to pregnancy? ☐ Yes ☐ No | Expected delivery date: |
|---|---|---|---|
| Is Disability due to illness or injury arising from Patient's employment? ☐ Yes ☐ No | Auto related? ☐ Yes ☐ No | Date of first treatment: | Date of most recent treatment: Date of next appointment: |
| Describe course of treatment: | | | Was the patient hospital confined? ☐ Yes ☐ No From: Through: |
| The patient has been continuously disabled (unable to work) From: Through: | The patient should be able to work on/or about: (Please indicate a specific date to avoid a delay in benefits) | | Date and type of surgical procedure: |
| Attending Physician (please print) | Physician's signature (no stamped signatures) | | Physician specialty: |
| Physician's address: | Telephone number: Fax number: | | Date: |

## Employer's Statement *Please Print*

| Employee's Name | | Occupation | Hourly ☐<br>Salary ☐ | Employment date |
|---|---|---|---|---|
| Weekly Wage | Weekly Benefit | Employee Status<br>Active ☐ Laid Off ☐ Retired ☐ | | Effective date of coverage |
| Date disability commenced | Date disability ceased | Vacation, Personal, Sick time used Yes ☐ No ☐<br>Dates used: | | Date last worked |

| Is this a recurrence within 2 weeks of previous disability? ☐ Yes ☐ No | Has employee returned to work?<br>Yes ☐ Date ☐ No |
|---|---|

Do you have any information which would assist Meritain in determining the merits of this case? Please explain.

Do you have any information regarding worker's compensation or other disability income benefits that would affect this claim? Please explain

**Please circle the job demands that apply to the employee:**

| **Demand Level**<br>% of working or frequency | **Occasional**<br>0-33%<br>1-4 reps per hour<br>1-32 reps per day | **Frequent**<br>34-66%<br>6-24 reps per hour<br>33-200 reps per day | **Constant**<br>67-100%<br>>24 reps per hour<br>>200 reps per hour |
|---|---|---|---|
| Sedentary | 10 pounds | Negligible | Negligible |
| Light | Up to 20 pounds | 10 pounds | Negligible |
| Medium | Up to 50 pounds | 20 pounds | 10 pounds |
| Heavy | Up to 100 pounds | 50 pounds | 20 pounds |
| Very Heavy | Over 100 pounds | Over 50 pounds | Over 20 pounds |

Employee's job requires: % Standing % Bending % Twisting

**LIST INDIVIDUAL DEDUCTIONS**: (Indicate applicable taxes/deductions)

Federal Tax _____% State Tax _____% Other _____%

| **PRE-TAX DEDUCTIONS** | | **AFTER TAX DEDUCTIONS** | |
|---|---|---|---|
| MEDICAL INSURANCE | $ _____ | CHILD SUPPORT | $ _____ |
| DENTAL INSURANCE | $ _____ | SPOUSAL SUPPORT | $ _____ |
| FLEX | $ _____ | OTHER _____ | $ _____ |
| OTHER _____ | $ _____ | OTHER _____ | $ _____ |

| Employer's representative (please print) | Signature of Employer's representative |
|---|---|
| Title:<br>Company Name:<br>Group Number:<br>Address:<br>Phone number: Fax number : | Submit claims to: Meritain Health<br>2370 Science Parkway<br>Okemos, MI 48864<br><br>Phone: 517-349-7010 Ext: 2187 Fax:517-381-6768 |

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# Authorization for Release of Protected Health Information (PHI)

My health record is private and is known under the law as "Protected Health Information (PHI)".

By completing and signing this form, I, or my legal representative, agree to allow Meritain Health and any of its parents, subsidiaries and affiliates, and their respective employees, agents and subcontractors, to share my PHI with the people or companies listed below.

**I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY.**

**Please submit a separate Authorization for Release of Protected Health Information (PHI) for each plan member for whom Meritain Health is being requested to disclose PHI to a third party. If both sides of this form are not completed, as applicable, Meritain Health will be unable to process your request. Incomplete authorization requests will be returned.**

***Please print all responses***

| **1. Member Information** | | | | |
|---|---|---|---|---|
| Last Name | | First Name | | Middle Initial |
| ID Number | Group Number or Group Name | Birth Date *(MM/DD/YYY)* | Phone Number *(Including Area Code)* | |
| Street Address | | City | State | Zip Code |

| **2. Employee Information** *(Please complete this section if the employee is not the member whose records are being requested.)* | | | | |
|---|---|---|---|---|
| Last Name | | First Name | | Middle Initial |
| ID Number | Group Number or Group Name | Birth Date *(MM/DD/YYY)* | Phone Number *(Including Area Code)* | |
| Street Address | | City | State | Zip Code |

| **3. I authorize the individual(s) or company(ies) identified below to receive PHI pertaining to the member identified in Section 1 above.*** | | | |
|---|---|---|---|
| Individual or Company Authorized to Receive PHI | | | Phone Number *(Including Area Code)* |
| Street Address | City | State | Zip Code |
| Individual or Company Authorized to Receive PHI | | | Phone Number *(Including Area Code)* |
| Street Address | City | State | Zip Code |
| Individual or Company Authorized to Receive PHI | | | Phone Number *(Including Area Code)* |
| Street Address | City | State | Zip Code |

**4. Purpose(s) for this Authorization**

**I only want to share the PHI I havechecked below. This authorization cannot be used to share psychotherapy notes. (Check all that are appropriate)**

- ❑ Any information requested
- ❑ Disability
- ❑ Life Benefits
- ❑ Patient management records
- ❑ Claim status
- ❑ Health (this includes medical, dental, pharmacy, vision, and flexible spending account information)
- ❑ Behavioral Health (e.g. mental health, drug and alcohol abuse treatment, but NOT psychotherapy notes)
- ❑ Long term care
- ❑ Application or enrollment information
- ❑ Claim records

❑ Other (please explain) _____

**This authorization will be valid for 1 year from the date signed, unless you indicate a shorter period below.**

_____ ***MM/DD/YYYY*** **through** _____ ***MM/DD/YYYY***

***NOTICE TO RECIPIENT(S) OF INFORMATION (Section 3 on page 1):**
Information disclosed to you pertaining to certain conditions, such as treatment for alcohol or drug abuse, HIV/AIDS and other sexually transmitted diseases, behavioral health, and genetic marker information is protected by various federal and state laws which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by such laws. Any unauthorized further disclosure in violation of state or federal law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient consent for release of these types of information. The federal rule at 42 CFR Part 2 restricts use of the information disclosed to criminally investigate or prosecute any alcohol or drug abuse patient.

**5. IMPORTANT: Your signature below means that you understand and agree to the following**

- My PHI that I agree to share may be sensitive. It may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases, sexually transmitted diseases, HIV/AIDS, and/or genetic marker information.
- Whoever gets my PHI may share it with others. That means federal or state privacy laws may no longer protect my PHI. ***Oklahoma Residents:*** You may have additional protections under Section 1-502.2 of the Oklahoma Statutes if the type of information to be released relates to HIV/AIDS and/or sexually transmitted disease information.
- If we receive requests for copies of claims/ encounter information from the individual or company you have named in Section 3, we may charge a reasonable fee (except where prohibited by law) to defray our copying and mailing costs.
- I can get a copy of this authorization form that I have signed by sending Meritain Health a signed request using the address at the bottom of this page.
- Your ability to enroll in a Meritain Health plan, and your eligibility for benefits and payment for services, will not be affected if you do not sign this form. (However, without your signature, your request to release information to the individual(s) named in Section 3 above will not be honored.)
- You may receive a copy of this signed form if you ask for it by writing to the address listed at the bottom of this page.
- You may cancel or change this authorization at any time by notifying Meritain Health in writing at the address below. Revoking this authorization will not have any affect on actions that Meritain Health took before getting my request..

**6. Signature of Member or Member's Legal Representative**

**ATTENTION:**

My signature is required if any of the below apply:

- I am 18 years of age or older
- I am a minor under the age of 18 and I am either married or emancipated
- The information being disclosed pertains to drug or alcohol treatment
- The information being disclosed pertains to one of the following conditions and my state allows me to be treated even if my parents or legal guardian do not agree with my decision:
  - Mental health
  - Sexually transmitted disease (including HIV/AIDS)
  - Reproductive health (including contraception, prenatal care and abortion)
  - General medical and dental health

| Signature | Date | Signature | Date |
|---|---|---|---|
| | | | |
| Print Name | | Print Name | |
| | | | |

**If the person signing this Authorization is not the member**, describe relationship to the member (i.e. Parent/Legal Guardian, Legal Representative):

**If this authorization is being signed by the Member's Legal Representative, you must provide the relevant legal document authorizing you to act on the Member's behalf (e.g. Power of Attorney, Legal Guardianship, Executor of Estate).**

**If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete.**

**Return this completed form and relevant documentation, if required, to:**
**Meritain Health**
**Attn: HIPAA Compliance Officer**
**P.O. Box 1671**
**Amherst, NY 14226-7671**

**Or you can fax it to: 716.319.5589**