



**INSTRUCTIONS to the EMPLOYEE**

- Complete and Sign the EMPLOYEE section of the form (below) and the HIPAA authorization (page 2).
- Have your doctor complete the PHYSICIAN section of this form (on page 3).
- Give the completed EMPLOYEE and PHYSICIAN forms to the Ancira Team Services office. The Team Services office will complete the remaining verification and submit your claim on your behalf. You will be mailed a final copy for your records.
- Filing a claim containing false, misleading, or deceptive statements is considered insurance FRAUD. Perpetrating fraud may result in dismissal from employment, disenrollment or denial of benefits and may subject the individual to civil or criminal penalties your employer has no control over.

**PART A: EMPLOYEE SECTION**

All blanks must be completed. Failure to complete this form entirely may cause delays. This form is for Disability Income Benefits only. Benefits are based upon your average income and the established premium collected through your payroll. Benefits are not taxable and will not exceed 60% of your average income. If you over-insured your income, you will be eligible to receive a refund of overpaid premiums for the preceding 12-month period. If approved for benefits, payments are dependent upon your doctor's certification of "disability" and will be mailed to your home mailing address. Your eligibility waiting period for benefits is 7 days.

A. Employee's name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (M.I.) \_\_\_\_\_ Date of Birth \_\_\_\_\_

B. Address (Street) \_\_\_\_\_ PO Box \_\_\_\_\_  
 (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Zip Code) \_\_\_\_\_  
 Home Phone # ( \_\_\_\_\_ ) \_\_\_\_\_

C. Date and reason for applying for Disability \_\_\_\_\_

D. Injury or accident happened?  at home  place of employment  other-explain \_\_\_\_\_

E. If injury arose out of or in the course of your job duties,  
 when was this reported to your employer? \_\_\_\_\_

F. Date entered hospital \_\_\_\_\_ Date discharged \_\_\_\_\_

**NOTICE:** If you are currently obligated under Child Support, Federal Tax Lien, or similar, it is your personal duty during your absence to continue making these payments DIRECTLY TO THE AUTHORITY (for example, the Office of the Attorney General). UMR and your Payroll office are unable to do so.

\_\_\_\_\_  
Employee Signature

## HIPAA AUTHORIZATION

I hereby authorize use or disclosure of protected health information about me as described below.

1. The following specific person or class of persons or facility is authorized to make the requested use or disclosure.
2. In addition to my Employer, the following person or class of persons may receive disclosure of protected health information about me:  
His/her/its name is: UMR  
His/her/its address is: PO Box 8015, Wausau, WI 54402-8015
3. The specific information that should be disclosed is:
4. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. I may revoke this authorization by notifying UMR in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.
6. This authorization expires 1 year from the date of the individual's signature below.

**THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING.**

\_\_\_\_\_  
Signature of Individual  
(the person about whom the information relates)

\_\_\_\_\_  
Date of Individual's Signature

\_\_\_\_\_  
Date of Birth or Social Security No.

OR, if applicable

\_\_\_\_\_  
Signature of Guardian  
Representative of Patient's Estate

\_\_\_\_\_  
Date of Guardian's/Personal  
Representative's Signature

\_\_\_\_\_  
Description of Guardian's/Personal  
Representative's Authority to Act for  
the individual

**PART B**

**ATTENDING PHYSICIAN'S STATEMENT**

Patient's Name: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

1. **Diagnosis** \_\_\_\_\_ (ICD-9 Code)(s) \_\_\_\_\_

Hospitalization / dates \_\_\_\_\_ Surgery type / date \_\_\_\_\_  
(CPT code)(S): \_\_\_\_\_  
Where: Office \_\_\_\_\_ In Patient \_\_\_\_\_ Out Patient/23 hr \_\_\_\_\_

2. **Disability Onset**

First day unable to work due to disability \_\_\_\_\_ Anticipated return to work \_\_\_\_\_

Is the condition or injury a result of a work related accident?  Yes  No If pregnancy, (EDC) date \_\_\_\_\_

Is your patient able to perform the duties of his/her job?  Yes  No

If not, what specific restrictions and limitations does your patient have? \_\_\_\_\_

3. **Objective clinical findings** (x-ray, MRI, CT, labs, etc.) \_\_\_\_\_

Results and dates: \_\_\_\_\_

4. **Subjective findings** \_\_\_\_\_

5. **Treatment follow up**

Date of first visit \_\_\_ / \_\_\_ / \_\_\_ Date of most recent visit \_\_\_ / \_\_\_ / \_\_\_ Date of next visit \_\_\_ / \_\_\_ / \_\_\_

6. **Treatment Plan** Specific treatment, frequency and duration (therapies, medications, etc.)

7. **Supportive Service - Other treating providers**

Name & Address: \_\_\_\_\_ Telephone # (\_\_\_\_) \_\_\_\_\_

Name & Address: \_\_\_\_\_ Telephone # (\_\_\_\_) \_\_\_\_\_

8. **Remarks:** We are interested in any information that would be helpful to your patient for evaluation of this claim.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name (MD) \_\_\_\_\_ Specialty \_\_\_\_\_ Telephone # \_\_\_\_\_ Fax # \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Signature of MD completing form \_\_\_\_\_ Date \_\_\_\_\_

Physician Tax ID \_\_\_\_\_

Name of individual completing form, if other than MD \_\_\_\_\_ Title \_\_\_\_\_

**FORM IS INVALID IF NOT SIGNED BY THE PHYSICIAN AND DATED.**