

SHORT TERM DISABILITY BENEFITS CLAIM FORM

INSTRUCTIONS FOR FILING A CLAIM FOR SHORT TERM DISABILITY BENEFITS

- Employee completes Part A below and forwards to the physician.
 - Physician completes Part C on reverse side and returns form to employee.
 - Employee forwards the form to Employer who completes Part B below.
- Employer should send completed form to AmeraPlan, Inc. at address listed below.

PART A: TO BE COMPLETED BY EMPLOYEE

1. Name of Employee	2. Social Security Number
3. Address	4. Occupation.
5. Have you filed for state unemployment? Yes <input type="checkbox"/> No <input type="checkbox"/>	6. Date injury occurred or first symptoms of sickness appeared
7. If injury, state how and where it occurred.	
8. Was the injury or sickness caused by your work? Yes <input type="checkbox"/> No <input type="checkbox"/>	9. Has a Workers Compensation claim been filed? Yes <input type="checkbox"/> No <input type="checkbox"/>
10. On what date and time did you stop work? Date: Time: A.M. <input type="checkbox"/> PM <input type="checkbox"/>	11. Give date of return (or expected date of return) to work.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any insurance company or organization, employer, hospital, physician, surgeon or pharmacy to release any information acquired in the course of my examination or treatment or requested by AmeraPlan, Inc. A photo copy of this authorization shall be considered as effective and valid as the original. I also certify that all statements, including any accompanying statements are true, complete and correct to the best of my knowledge.

Signature: _____ Date: _____

AUTHORIZATION TO PAY BENEFITS TO PROVIDER: I hereby authorize payment directly to the undersigned provider of the hospital, surgical and/or medical benefits, if any, otherwise payable to me for the services as described below, but not to exceed the reasonable and customary charge for those services.

Signature: _____ Date: _____

PART B: TO BE COMPLETED BY THE EMPLOYER

1. Name and Address of Employer	
2. Name of Employee	
3. At the time of injury or sickness, was the employee on leave of absence or layoff? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, give date leave of absence or layoff started: Was coverage terminated? Yes <input type="checkbox"/> No <input type="checkbox"/>	
4. What was the last date worked?	5. Average weekly wage:

Signature: _____ Title: _____ Date: _____

EMPLOYER: Once Employee, Attending Physician's Statement and Employer sections are complete, return form to:

AmeraPlan, Inc.
3001 West Big Beaver Road, Suite 320, Troy, MI 48084
Phone (800) 221-4254 Fax (248) 643-9401

ATTENDING PHYSICIAN'S STATEMENT

1. Diagnosis and Concurrent Conditions (If diagnosis code other than ICDA used, give name.)

2. Is condition due to injury or sickness arising out of patient's employment? Yes No Accident? Yes No

3. Pregnancy? Yes No If yes, approximate date pregnancy commenced:

4. Report of Services (or attach itemized bill) If form submitted to this company previously, you need show only dates and services since last report.

Date of Services	Place of Services	Description of Surgical or Medical Services Rendered	Procedure Code (if code other than CPT used, give name)	Charges

<input type="radio"/> Doctor's Office <input type="radio"/> IH Inpatient Hospital <input type="radio"/> NH Nursing Home <input type="radio"/> H Patient's House <input type="radio"/> OH Outpatient Hospital <input type="radio"/> OL Other Locations	TOTAL CHARGES	\$
	Amount Paid	\$
	Balance Due	\$
ICDA International Classification of Diseases CPT Current Procedural Terminology (current edition)		

4. Date Symptoms First Appeared or Accident Happened: _____ 5. Date Patient First Consulted You For This Condition: _____

6. Patient Ever Had Same or Similar Condition? Yes No If yes, state when and describe. _____

7. Patient Still Under Your Care for This Condition? Yes No

8. Patient was Partially Disabled OR Continuously Totally Disabled from _____ through _____

9. If Still Disabled, Date Patient Should Be Able to Return to Work Date: _____ 10. Patient Was House Confined Yes No If yes, dates: from _____ through _____

11. Does Patient Have Other Health Coverage? Yes No If Yes, please identify. _____

Date	Physician's Name (Print)	Signature	Degree	Telephone
Street Address		City/Town	State/Province	Zip Code
Doctor's Tax Account No.	Individual Practitioner - Social Security No.			
	All Others - Employer Identification No.			

PROVIDER: Please return the completed form to the employee.