Guidelines for Filing Short-Term Disability (STD) Claims

In January 2002, new Department of Labor regulations were issued regarding the privacy of health information on Short-Term Disability (STD) claims. These regulations require plans to protect the privacy of the patient's health information. Therefore, the STD claim form was re-designed so the employer can not have access to protected health information provided by the employee's physician. Attached is the new Short Term Disability Claim Form. This is a 2-page form which must be completed by the employer, employee and physician.

Please review the form and read the following instructions carefully, before submitting your claim:

1. Please request that your employer complete Part I.

2. Please request that your physician complete Part II.

3. Part III must be completed by the employee.

4. **All three parts of the claim form must be completed in full. After all parts of the form have been completed in full, please return both pages to the STD Unit for processing.** The completed forms can be faxed or mailed to the address on the claim form. Failure to complete all sections and return both pages will delay the processing of your claim.

5. All claims will be reviewed by a medical review coordinator and then forwarded to the appropriate personnel for processing. The determination will be based on diagnosis, job classification, and industry-standard resources.

NCAS FAX (703) 934-6279

SHORT-TERM DISABILITY CLAIM FORM

INSTRUCTIONS: THE EMPLOYER, ATTENDING PHYSICIAN, AND EMPLOYEE MUST COMPLETE THIS FORM IN FULL. ALL QUESTIONS ON THE FORM MUST BE ANSWERED BEFORE THE CLAIM CAN BE CONSIDERED.

PART I: EMPLOYER'S STATEMENT (MUST BE COMPLETED BEFORE PHYSICIAN)

Employee Name:			Employee Identification Number:
LAST NAME	FIRST NAME	MI	

Date Of Employment Or Membership:	Employee's Effective Date Of Insurance:	Has Insurance Terminated? If Yes, Provide Date:

Any Prior Disability Claims For This Patient?	Is Patient Eligible For Worker's Compensation?

If Condition Related To Employment, Has Worker's Compensation Considered It?

If Yes, Attach Response From Worker's Compensation

Employee's Occupation:	Salary Per Week: Per Month: Per Year:

Select Job Classification Based on Employee's Required Physical Effort (See Definitions Below):

____ Sedentary Work ____ Light Work ____ Medium Work ____ Heavy Work ____ Very Heavy Work

Employee's Last Day Worked:	Has Employee Returned To Work? Yes - Date: No - Date Expected:
Will Employee Use Accrued Leave Prior to Short-Term Disability?	If Yes, Provide Last Date of Accrued Leave Use:
Name Of Employer:	Division Or Affiliate:

Signature Of Employer's Representative:	Title:	Date:

*********If Employee is on Partial Disability – Provide Weekly Update of Hours Worked *********

Job Classification Descriptions

- **Sedentary Work:** Exerting up to 10 pounds of force occasionally, and/or negligible amount of force frequently or constantly to lift, carry, push, pull or otherwise move objects.
- **Light Work:** Exerting up to 20 pounds of force occasionally, and/or in excess of 10 pounds frequently, and/or negligible amount of force constantly to move objects.
- **Medium Work:** Exerting up to 50 pounds of force occasionally, and/or in excess of 20 pounds frequently, and/or 10 pounds constantly to move objects.
- **Heavy Work:** Exerting up to 100 pounds of force occasionally, and/or in excess of 50 pounds frequently, and/or 20 pounds constantly to move objects.
- **Very Heavy Work:** Exerting in excess of 100 pounds of force occasionally, and/or in excess of 50 pounds frequently, and/or 20 pounds constantly to move objects.

SHORT-TERM DISABILITY CLAIM FORM

PART II: ATTENDING PHYSICIAN'S STATEMENT

Patient's Name:	Date Of Patient's Disability:	For Injury, Provide Date Of Accident:

Period Of Total Disability (Cannot Work) From Date: To Date:	Period Of Partial Disability (Can Do Light Work) From Date: To Date:
Date Patient Should Be Able To Return To Work:	For Pregnancy Provide EDC:

Diagnosis Or Nature Of Physical Incapacity To Perform Regular Job:

Surgery Performed:	Date Of Surgery or Delivery:

Medical Treatment Being Followed For This Diagnosis:

If Patient Hospitalized, Please Provide Dates Of Hospitalization:

Date Admitted: Date Discharged:

Physician's Name, Address & Telephone Number: **PLEASE PRINT**	Signature Of Physician: Date:

PART III: EMPLOYEE'S STATEMENT

Employee Name:			Date Of Birth:	Employee Social Security Number:
LAST NAME	FIRST NAME	MI		
Home Address:				Telephone:
STREET	CITY	STATE ZIP CODE		AREA CODE NUMBER
Is Disability Due to an Accident? _____ YES _____ NO				Sex: _____ Male _____ Female

If Yes, Please Provide Date, Place, And Details Of The Accident:

The above statements are true and complete to the best of my knowledge and belief and I hereby authorize any hospital or physician who has treated me or other person who has attended me or examined me or any company or government agency to furnish to National Claims Administrative Services, Inc. or their representative, any and all information with respect to any illness, injury, medical history, consultations, prescriptions, treatments or benefits and copies of all applicable records. A photostatic copy of this form will be as valid as the original.

Employee's Signature: Date Signed:	Employer Name:

PLEASE MAKE SURE THAT ALL THREE SECTIONS OF THE SHORT-TERM DISABILITY CLAIM FORM ARE <u>COMPLETED.</u> SEND FORM TO 'NCAS STD UNIT'.

BY FAX: (703) 934-6279 **or** BY MAIL: NCAS – STD UNIT
P.O. BOX 10118
FAIRFAX, VA 22038-8018