Short Term Disability Claim Form
Physician Statement

Anthem Life

Anthem Life Insurance Company
Disability Claims Service Center
PO Box 105426
Atlanta, GA 30348-5426
Phone: 800-813-5682 Fax: 800-850-0017
Email: lifeanddisabilityclaims@anthem.com

SECTION 3: TO BE COMPLETED BY PHYSICIAN

Note to Physician: Completion of this form will assist your patient in presenting a claim for disability benefits. Please complete all areas of the form; if a section is non-applicable, please enter N/A in the response area.

Patient name (last, first, M.I.)			Birthdate (MM/DD/YYYY)
Current diagnosis		ICD-9 code/DSM IV	
Subjective complaints		Objective findings	
Has patient ever had same or similar condition? ☐ Yes ☐ No	If yes, please specify dates of treatment	Did injury or illness arise out of or in course of employment for wages or profit? ☐ Yes ☐ No ☐ Unknown If yes, please explain: _____	
Is disability due to pregnancy? ☐ Yes ☐ No	If yes, LMP (MM/DD/YYYY)	EDC (MM/DD/YYYY)	Type of delivery ☐ Vaginal ☐ C-section
Was patient hospitalized? ☐ Yes ☐ No	If yes, please provide date of confinement	Name of hospital/facility	
Nature of surgical procedure, if any. Describe in full (Add additional sheets if necessary).			Date performed (MM/DD/YYYY)
Date patient first unable to work	Date of first visit	Date of last visit	Patient's present condition
Frequency of visits ☐ Weekly ☐ Monthly ☐ Other: _____		Treatment plan	
Functional impairments		Current medications and dosages	
Patient released to return to work? ☐ Yes ☐ No If yes: ☐ Full-time, no restrictions ☐ Light duty (Please specify restrictions, limitations, hours, graduated return to work schedule, etc.)		Date able to return to full duty	Date able to return to light duty
Is this patient a suitable candidate for a rehabilitation program? ☐ Yes ☐ No		Is this patient competent to endorse checks and direct the proceeds thereof? ☐ Yes ☐ No	
Physician printed name			Physician specialty
Physician street address		City	State / ZIP code
Physician phone no.	Physician fax no.	Physician email address	
Signature of physician **X**			Date (MM/DD/YYYY)

Si usted necesita ayuda en Español para entender este documento, puede solicitarlo sin ningun costo adicional llamando al número de servicio al cliente que se encuentra en este documento.

Individual Authorization Form

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Section A

I authorize my health care providers including but not limited to any health care professional, hospital, clinic, laboratory, pharmacy or other medically related facility or service, rehabilitation professional; vocational evaluator; insurance company; reinsurer; insurance service provider; third party administrator; health plan/insurer/HMO/administrator and its subcontractors, life and disability insurer and its subcontractors, to use, exchange and disclose to each other the information set forth in Section B below.

Section B

I authorize the parties listed in Section A above to use, exchange and disclose to each other medical and insurance information related to health, dental, life and disability products. This includes, but is not limited to, information regarding benefits, enrollment, claims, providers, diagnosis information, precertification, case management, appeals, medical records, and financial information. Information about my health may relate to any disorder of the immune system including but not limited to, HIV and AIDS; use of drugs and alcohol; and mental and physical history, condition, advice or treatment.

Section C

I understand that my information is being shared by and among the parties listed in Section A above for evaluating and administering my claim(s) for benefits, which include assisting me in returning to work.

Section D

If not previously revoked, this authorization is valid for one year from the date below, or the duration of my claim, whichever period is shorter.

Section E

A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original. I understand that if this information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans covered by federal privacy regulations, my information provided in this document may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations. I have the right to revoke this authorization at any time, except to the extent that the person/company has already taken action on the disclosure provisions contained in this document. If I choose to revoke the authorization, I must notify the person/company identified in Section A in writing that I request termination of this authorization.

Section F: Employee information

Last name	First name	M.I.	Birthdate (MM/DD/YYYY)	Social Security no.

Street address	City	State	ZIP code

Employee signature **X**	Date (MM/DD/YYYY)

If this authorization is signed by a legal representative on behalf of the individual, please complete the following and attach a copy of the representative's authority to this form (e.g., Health Care Power of Attorney, Executor/Administrator of an estate).

Personal representative name	Relationship to member

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REIMBURSEMENT AGREEMENT

Employee's Name: _____
Last First Middle

Employee's last 4 digits of Social Security Number _____ First Day Absent _____

Employer _____ Group # _____

I acknowledge that I am eligible for benefits under the disability plan sponsored by the above named employer whose claims for plan benefits are either insured by or administered on an employer self-funded basis by Anthem Life Insurance Company (hereinafter referred to as Anthem). I agree to reimburse Anthem 100% of the amount of benefits I receive, have received, or shall receive from any person or entity for loss of wages incurred as a result of the occurrence which gave rise to my claim for payment of benefits from the disability plan. In the event that the 100% reimbursement provided in the preceding sentence is greater than the amount of my recovery, less attorney fees and other legal expenses I incurred in obtaining such recovery (my net recovery), I agree to reimburse Anthem the entire amount of my net recovery.

I agree to keep Anthem fully informed as to the status of my payment recovery so that Anthem may take whatever action it deems necessary to protect its interest. I also agree to authorize any person including, but not limited to, any insurance company, attorney, hospital, physician, surgeon or pharmacist to release to Anthem any information pertaining to this occurrence, or claim.

I also acknowledge that Anthem will have the right to recover any overpayment of benefits, either directly from me or by deduction of the amount of the overpayment from my future benefits payable under the disability plan, which are the result of error caused by or misinformation provided to the Anthem.

_____ _____
Signature Date

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COMMUNICATION CONSENT FORM

The Telephone Consumer Protection Act of 1991(TCPA), the Federal Communications Commission's (FCC) regulations and interpretative orders implementing the TCPA, the Federal Trade Commission's (FTC) Telemarketing Sales Rule of 2003 (TSR), and parallel state laws (collectively referred to as the Telecommunications Laws) impose strict rules governing how Anthem Life Insurance Company (Anthem) may place outbound telephone calls and send text messages for Sales and Non-sales purposes to individuals.

In order to comply with the new federal regulation, please provide below what numbers we can contact you on in regard to your claim.

Phone number you wish to be contacted on: _____

This phone is: __ Cell phone or __ Land Line

Is this phone number registered on the National Do Not Call Registry? __ Yes __ No

Does Anthem have permission to contact you on this number? __ Yes __ No

Print your name: _____

Your signature: X_____

Date signed: _____ (MM/DD/YYYY)