Disability Form Information

Payment Received? ☐

Account #: _____ **Physician:** _____

A fee of $15.00 per form is due before forms can be released.

Please allow **seven (7) business days** for completion of forms.

Patient Name: _____ **DOB:** _____

Address: _____ Phone:_____

_____ Email: _____

City: _____ State: _____ Zip: _____

Indicate preferred method of delivery of completed form:

☐ Mail to Patient (address above)

☐ Mail to Insurance Company

Mailing Address: _____

_____

_____

_____

☐ Fax to Insurance Company

Fax Number: _____

Attention to: _____

Comments / Instructions: _____

Number of Forms: _____ Date of Surgery Scheduled: _____

I authorize BACTES Imaging Solutions, a trusted Business Associate of Ozark Orthopaedics, to release medical information to insurance carriers regarding disability claims.

I understand that:

- My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
- I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
- I can request a copy of this form after I sign and date it.

Signature: _____ Date: _____

This authorization expires 90 days from the date of signature.

All forms are completed in the order that they are received.

All form fees are due when request is submitted.

Should you have any questions, please call (479)202-0058.

Updated 03-18-2014