

Disability Form Information

Payment Received?

Account #: _____

Physician: _____

A fee of \$20.00 per form is due before forms can be released. Please allow seven (7) business days for completion

Patient Name: _____ DOB: _____

*Dates of Leave you are requesting to be off work : _____ to _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Indicate preferred method of delivery of completed form:

Mail to Insurance Company

Mailing Address: _____

Fax to Insurance Company

Fax Number: _____
Attention to: _____

Comments / Instructions: _____

I authorize 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)587-3122

Updated 08-08-2016