



FORM COMPLETION POLICY & FEE SCHEDULE

Department Hours

Monday - Thursday, 8 a.m. thru 4:30 p.m.

To save cost, our office has developed a *generic* disability form accepted by many insurance companies. You may download and complete this form and mail it into our office for the physician to complete.

If you must have a *specific* form, our office will be happy to complete it for you. It is our policy to collect a pre-paid fee for this service:

| | |
|--|-----------------------|
| Disability Information Form (Standardized - provided by SOS) | <i>FREE</i> |
| Disability Insurance Form (provided by Insurance Co.) | \$ 15 initial form |
| | \$ 5 subsequent forms |
| Creditor Disability Form | \$ 15 initial form |
| | \$ 5 subsequent forms |
| Family Medical Leave Act | \$ 20 |
| Attending Physician Statement (Dictation Request) | \$ 35 - \$ 40 |
| Medical Narrative | \$ 75 - \$200 |

**** CERTAIN FORMS NOT MEETING THESE CLASSIFICATIONS WILL BE INDIVIDUALLY QUOTED.**

Please complete and sign the "Patient" portion of your form before submitting it for completion by the physician.

Thank You



FREE DISABILITY FORM

THERE IS NO CHARGE FOR THE FOLLOWING FORM IF COMPLETED BY PATIENT. THE FORM MUST BE REVIEWED AND SIGNED BY THE PHYSICIAN AFTER THE PATIENT PORTION HAS BEEN COMPLETED.

Southern Orthopaedic Specialists

DISABILITY CLAIM REPORT

Instructions for Completion of Form:

1. Please PRINT all information clearly.
2. To avoid delay, be certain all information given is exact.
3. Attach your insurance company's form (be certain you have signed both forms) and return to our Insurance Dept.

PART A TO BE COMPLETED BY PATIENT

NAME _____ SS# _____
LAST FIRST MI POLICY # _____
ADDRESS _____ BIRTHDATE _____
EMPLOYER _____
PHONE (HOME) _____ OCCUPATION _____
(WORK) _____

NATURE OF DISABILITY ILLNESS _____ WORK INJURY _____ ACCIDENT _____
Date Date Date

DATES OF TOTAL DISABILITY FROM: _____ TO: _____

DATES OF PARTIAL DISABILITY FROM: _____ TO: _____

PHYSICIAN YOU FIRST CONSULTED FOR THIS CONDITION _____
DATE _____

I AUTHORIZE SOUTHERN ORTHOPAEDIC SPECIALISTS TO RELEASE TO THE PAYOR ANY INFORMATION NECESSARY IN THE COMPLETION OF THIS FORM

PATIENT SIGNATURE _____

DATE _____

PART B TO BE COMPLETED BY PHYSICIAN

CHART # _____ ACCOUNT # _____

DIAGNOSIS/ICD9 CODE & DESCRIPTION _____

TREATMENT DATES (LAST 3 MOS.) _____

IF RETURN TO WORK DATE IS UNKNOWN,
ESTIMATE CONDITION IMPROVEMENT 1-2 MOS. 3-4 MOS. 4-6 MOS. OTHER NEVER

CURRENT RESTRICTIONS/LIMITATIONS _____

REMARKS _____

TO THE BEST OF MY KNOWLEDGE,
_____ PART A IS CORRECT
_____ PART A IS CORRECT W/ THE NOTED EXCEPTIONS IN PART B
_____ I DO NOT HAVE SUFFICIENT INFORMATION TO VERIFY THE INFORMATION GIVEN IN PART A

PHYSICIAN SIGNATURE _____ DATE _____