MIDLANDS ORTHOPAEDICS, P.A.

DISABILITY FORM PROTOCOL

Midlands Orthopaedics, PA has developed a standard form for disability benefits that will be sent to your disability carrier.

There is a $20.00 processing fee for each form and any updates. This is payable by you to HealthPort and may be made via check, money order, or the attached credit card payment form. Cash payment is not accepted.

Forms will not be processed without payment.

Read and complete the Claimant Information for Disability Benefits form in its entirety (two pages). Mail the completed forms and payment to:

Midlands Orthopaedics, P.A.
On-Site HealthPort Representative
1910 Blanding Street
Columbia, SC 29201

If you are paying via credit card, all forms may be faxed to 803.753.9814

Allow **up to ten business days** for the request to be processed.

Any questions concerning the status of your request should be directed to 803.933.6175 or smart@midlandsortho.com.

MIDLANDS orthopaedics, p.a.

1910 Blanding Street Columbia, SC 29201
(803) 256-4107

CLAIMANT INFORMATION FOR DISABILITY ACCIDENT-DISMEMBERMENT BENEFITS

SOCIAL SECURITY # ☐ -- ☐ -- ☐

PATIENT NAME DATE OF BIRTH / /

STREET ADDRESS

CITY STATE ZIP

THIS FORM IS FOR DISABILITY INCOME INSURANCE, DISABILITY INSURANCE FOR CREDITORS, ACCIDENT – DISMEMBERMENT, AND HOSPITAL INCOME CLAIMS.

PLEASE GIVE A BRIEF DESCRIPTION OF DISABILITY, OR ACCIDENT, AND LIST DATE BELOW

WAS THIS THE RESULT OF _____ SICKNESS _____ ACCIDENT ______ INJURY

WAS THE CLAIMANT: ☐ INPATIENT ☐ OUTPATIENT DATE ________________________

IF INPATIENT: ADMISSION DATE ☐ DISCHARGE DATE ☐

IS THIS WORK RELATED? ☐ Yes ☐ No

NAME OF REFERRING PHYSICIAN ☐

FAILURE TO COMPLETE THE FOLLOWING SECTION WILL CAUSE A DELAY IN COMPLETION OF YOUR DISABILITY FORM

	Date
Your first treatment for this illness or injury with our Physicians	
Your most recent treatment for this illness or injury	
Did the claimant ever have the same or similar condition before.	Y or N
Date claimant will be able to perform his/her normal schedule	
Date claimant will be able to perform light duty	
Are you participating in formal Physical Therapy..	Y or N

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CLAIMANT INFORMATION FOR DISABILITY / ACCIDENT / DISMEMBERMENT BENEFITS

Midlands Orthopaedics, P.A. has developed a standard form for Disability Benefits. This form will be used for Short-Term Disability, Long-Term Disability and updating information. **We no longer complete carrier-specific disability forms**; **however**, **we will provide you with a Midlands Orthopaedics disability form which will include all necessary information**. A letter will be included with this form notifying your insurance company of this change. **Due to the volume of requests we receive on a daily basis, it may take up to 10 business days to complete your form(s)**. HealthPort has been contracted to provide this service.

Please put the name, address, and fax number where you need your forms to be sent below:
Name______________________________Address____

City/State/Zip____Fax# (   )____________________

A processing fee is charged at the rate of $20 per form for this service and is payable by you prior to completion. If payment for completion is not received at the time the form is received, our office will contact you. Make check or money order payable to HealthPort.

Other Disability Issues:

Please keep in mind that if your Midlands Orthopaedics doctor states you can perform light duty and your employer does not have light duty assignments, your employer will be responsible for declaring you "out of work", not your physician. In order to expedite the processing of your claim(s), copies of the medical records in support of your claim(s) will be sent with this form.

For completion of **Physical Capacity** or **Limitation** form(s):

If you are seeing a physical therapist, he/she is responsible for completing this form. If this is not done, your benefits may be delayed.

For completion of **Work Certificate** or **Family Medical Leave Act (FMLA)** form(s):

Please contact the Forms Department at 803-933-6132 or fax your form(s) to 803-253-6655 with complete details as to where to send it upon completion.

It is your (the patient's) responsibility to ensure that a work-status statement is obtained at each visit; otherwise, disability income may be delayed. We suggest you make a copy of your work-status statement and give it to your employer/nurse case manager immediately after each visit to facilitate prompt payment of benefits.

Signed: ____ Date: ________________________

*******DO NOT SCAN*******

Credit Card Payment

________***I authorize HealthPort to Charge my card for the amount stated below.***
(Please initial)

__________ __________ __________ __________ (__________)
Credit Card Number – **VISA/MASTERCARD ONLY** Expiration Date

$______________________
Amount to Charge Account

X____
Signature of Cardholder

____
Name on Credit Card (Please Print)

____
Billing Address of Cardholder

____
City, State, Zip Code

(Please do not write below this line, for HealthPort Use Only)

____
Field Request ID (Please Write Number Here)

HealthPort Representative:
Do not scan this paper, send in to Corporate Office to the attention of:

HealthPort
Attn: Chris Hodges
120 Bluegrass Valley Parkway
Alpharetta, GA 30005

*******DO NOT SCAN*******