DELTA HEALTH SYSTEMS
Administration Services

Weekly Disability Verification
Required to receive disability benefits

Important: Failure to return this form promptly may result in the delay of payment for disability benefits.

Part 1-To be completed by EMPLOYEE

Name		Date:
Address		
Date of Birth		Health Care Identification Number (HCID):
Daytime Phone number		
Date and time of the accident or onset of disability.		
Where did the accident or the onset of disability occur?		
Is this condition/injury related to employment?		
If due to an accident, please provide details of how the accident occurred.		
First date you were unable to work?		
Have you returned to work? If yes, please provide the exact date		
List any dates you have worked between the first day you were unable to work and the date on this form.		

Medical History Release Authorization

I authorize any medical information relating to this claim to be disclosed to and acquired by the Administrator of this Plan and such agents or the Administrator as are necessary to process this claim. Such information may be disclosed by a health care provider or other plan administrator. This authorization shall remain valid as long as I am disabled and required to provide weekly disability verification(s). I agree that a photocopy of this authorization shall be valid as an original signature.

Employee Signature:_____

Part 2-To be completed by PHYSICIAN

This information is required to initiate Weekly Disability Benefits; follow-up verification may be requested.

Patient Name		
Diagnosis of Employee ICD-10 code(s)		
Date the employee first sought treatment		
Is the condition/injury related to the employee's employment?		
Is the condition/injury related to an accident?		
Symptoms		
Activities permitted with current condition/injury		
Was this employee referred to you? If so, please list his/her name, address and phone number.		
Have you referred this employee to any other physician(s)? If so, please list his/her, address and phone number.		
Is the employee still under your care? If no, please provide the date of last visit.		
Dates of Disability (i.e., Total and Continuous Disability)	Start Date:	End Date:

YOUR PARTNER IN HEALTHCARE SOLUTIONS

Phone: 800-417-8923 Post Office Box 80 Stockton, CA 95201-3080

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To be completed by PHYSICIAN (Continued)

Have any surgical procedures been performed? If so, please list.	Surgery Date(s)	Type of Surgery Performed	If hospitalized for this surgery:	
			Date Admitted	Date Discharged
Other than the surgical procedures listed above, has this patient been hospitalized? If so, please list.	Reason for Hospitalization		Date Admitted	Date Discharged
Other medical, non-surgical treatments?				

Verification by Physician

Physician's Signature		Date:
Physician's Name (Please Print)		
Degree/Practice Speciality		
Physician's Office Address		
Physician's Office Telephone Number		
License Number		
Federal Tax ID Number		