

Claim Statement of Employee

PART I (To be completed by Employee)			
Employee Name		Date of Birth	Employee ID Number
Employee Home Address		City	State Zip
Work Phone		Home Phone	
Occupation	Social Security Number	Regular Monthly Salary	Last Day Worked before Disability Began
Date accident occurred or sickness began			
Nature of sickness or injury			
Is condition due to injury or sickness arising out of employment?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If sickness, when were first symptoms noticed?			
If injured, how and where did the accident occur?			
Name & address of physician (for all physicians consulted)			
Date first treated			
Have you been confined to a hospital?		If Yes, Admitted:	Discharged:
Name & address of hospital			
On what date did you or do you expect to resume your usual duties?			
Have you filed, or do you intend to file, this claim under Worker's Compensation?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you filed, or do you intend to file, for Public Employees' Retirement Benefits or STRS Disability Benefits?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, please indicate amount:			

I hereby authorize any hospital, physician, or other person who has attended me or examined me to disclose when requested to do so by United Administrative Services, any and all information with respect to any illness or injury, medical history, consultation, prescription, or treatment, and copies of all hospital or medical records. A photocopy of this authorization shall be considered as effective and valid as the original.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

Employee's Signature	Date

Return completed form to:



United Administrative Services

PO Box 5057, San Jose, CA 95150
1120 South Bascom Avenue, San Jose, CA 95128
Phone: 408.288.4400

PART II – Attending Physician’s Statement

DIAGNOSIS AND CONCURRENT CONDITIONS (if diagnosis code other than ICDA used, give name)

Is condition due to injury or sickness arising out of patient’s employment?		Pregnancy?		If yes, approximate date pregnancy commenced:	
<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> No		

Report of Services (Or attach itemized bill) (If previous form submitted to this carrier, you need to show only dates and services since last report)

Date of Services	Place of Services*	Description of Surgical or Medical Services Rendered	Procedure Code – If Used (if code other than CPT used, give name)	Charges

* O – Doctor’s Office	OH – Outpatient Hospital	Total Charges
H – Patient’s Home	NH – Nursing Home	Amount Paid
IH – Inpatient Hospital	OL – Other Location	Balance Due

Date symptoms first appeared or accident happened **Date patient first consulted you for this condition**

Patient ever had same or similar condition? **Patient still under your care for this condition?**

<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, when and describe:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Patient was continuously, totally disabled (unable to work) Patient was partially disabled

From	Through	From	Through
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If still disabled, date patient should be able to return to work Patient was house-confined

From	Through
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Does patient have other health coverage?

<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, please identify:
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Physician’s Name **Taxpayer Identification Number** **Phone**

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Address **City** **State** **Zip**

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I authorize the release, to United Administrative Services, of any and all medical records pertaining to the above patient.

Physician’s Signature **Degree** **Date**

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