

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	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<input type="checkbox"/> Patient was continuously, totally disabled (unable to work)		<input type="checkbox"/> Patient was partially disabled	
From _____	Through _____	From _____	Through _____

If still disabled, date patient should be able to return to work _____		<input type="checkbox"/> Patient was house-confined	
		From _____	Through _____

Does patient have other health coverage?	
<input type="checkbox"/> Yes	<input type="checkbox"/> No

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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