Johns Hopkins Employer Health Programs
Attention Short Term Disability
6704 Curtis Court
Glen Burnie Maryland 21060

Group Disability Claim Form
Phone: (410) 762-5312
Fax: (410) 762-5313

Last Name:	First Name:	Initial:
Address:	City: State:	Zip:
Date of Birth: / / / Date of Hire: : / / /	Telephone: ( )	
Soc. Sec. Num:	Employer:	
Occupation:	Dept: Telephone:	
Supervisor:	Hourly amount: Weekly Salary:	

Check One:

☐ Injury _____

_____

_____

☐ Illness Please state your illness: _____

State your first symptoms: _____

_____

☐ Pregnancy Please go to Box B below

Box A: Illness or Injury:		
Date of illness or injury: / /	Date you were first treated by a doctor: / /	
Did disability arise out of employment?	☐ Yes ☐ No	
If yes, did you file a Workers' Compensation Claim	☐ Yes ☐ No	
Describe why you are unable to work:		
Last day you worked before becoming disabled: / /	Did you work a full day? ☐ Yes ☐ No	

Box B: Pregnancy		
EDC Date: / /	Date you were first treated by a doctor: / /	
If you are unable to work until your delivery date, please state the reason		
Doctor's Name:	Specialty:	Phone: ( )
Doctor's Address	City: State:	Zip:

List any other doctor you are seeing regarding this claim:

Name: _____ Specialty: _____

Address: _____ Telephone: ( )

Name: _____ Specialty: _____

Address: _____ Telephone: ( )

The above information, including any accompanying statements, is to the best of my knowledge accurate and complete. This authorized you to give Johns Hopkins EHP any information, data, and medical records regarding my medical history and treatment (including any records pertaining to drug, alcohol, and psychiatric treatment and workers compensation) required for processing this claim. A copy of this authorization may be honored.

Claimant Signature: _____ Date: _____

FOR EHP USE ONLY:	
Date Received: / /	**Claim needs medical review:** ☐ **Yes** ☐ **No**
If Yes, why:	
Date sent for medical review: / /	
STD Coordinator signature:	**Date:** / /

Attending Physician's Statement: To be completed in full by the physician who was treating the claimant when he/she last worked.

Patient's name: Date disabled: / /
Primary diagnosis, including ICD9 Code:
Patient's complaints:
Objective findings:
Is this patient's condition work-related? ☐ Yes ☐ No If yes, explain:
Has patient undergone surgery for this condition? ☐ Yes ☐ No If yes, give date, procedure and outcome: If no, do you expect surgery to be performed in the future? ☐ Yes ☐ No If yes, give date and type of surgery:
List medications the [patient is currently taking for this condition:
Please indicate other types and frequencies of treatment:
Has the patient been referred to a medical rehabilitation or therapy program? ☐ Yes ☐ No If yes, give detail:
Have you referred the patient for other types of consultations? ☐ Yes ☐ No If yes, give details:

Has the patient been confined in a hospital? ☐ Yes ☐ No If yes, complete the following:
Hospital name and address: Dates of confinement:
Briefly describe restrictions (what the patient cannot do):

Complete this section if patient is pregnant: EDC: / / Has patient delivered? ☐ Yes ☐ No If yes, give method of delivery: If patient is to stop working prior to delivery date, please specify the medical necessity and complications:

What is your prognosis for recovery?	☐ Full	☐ Partial	☐ Excellent	☐ Good	☐ Fair	☐ Poor
Is patient now totally disabled? ☐ Yes ☐ No						
Date patient can return to work: / / ☐ Full-time ☐ Part-time hrs/week?						
Next follow-up Appointment: / / Estimated frequency of appointments:						

Please attach copies of office notes for the period of treatment or the last two years, test results showing objective findings, and consulting physician reports.

Fraud Notice: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

Your Name: _____ Degree: _____ Phone: ( )_____

Address: _____

Signature: _____ Date: / /