



Johns Hopkins Employer Health Programs
Attention Short Term Disability
 7231 Parkway Drive, Suite 100
 Hanover, Maryland 21076

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: : / /	Phone: () SSN: / /
Occupation:	Employer:	
Supervisor:	Dept:	
Supervisor's Email:	Supervisor's Phone ()	

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, did you file a Workers' Compensation Claim	<input type="checkbox"/> Yes <input type="checkbox"/> No
Describe why you are unable to work:	
Last day you worked before becoming disabled: / /	Did you work a full day? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain:			
Has patient undergone surgery for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give date, procedure and outcome:			
If no, do you expect surgery to be performed in the future? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give detail:			
Have you referred the patient for other types of consultations? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give details:			

Has the patient been confined in a hospital? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give method of delivery: If patient is to stop working prior to delivery date, please specify the medical necessity and complications:
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What is your prognosis for recovery?	<input type="checkbox"/> Full	<input type="checkbox"/> Partial	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Is patient now totally disabled? <input type="checkbox"/> Yes <input type="checkbox"/> No						
Date patient can return to work: / /	<input type="checkbox"/> Full-time	<input type="checkbox"/> 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: _____ / _____ / _____