Short-Term Disability Claim Recertification Application

Mid-America Carpenters Regional Council Health Fund (Fund)
Northern Illinois Region
12 E. Erie St, Chicago, IL 60611
Phone: (312) 787-9455, option 3 | Fax: (312) 337-6496 | Email: submit@macbenefits.org

You cannot initiate a claim with this application. This application is for the continuation or termination of an existing, approved disability benefit. If this is your first time filing for disability for a current condition, complete a Short-Term Disability Claim application.

Complete Part 1 in full; your physician must complete Part 2.

Failure to complete this application in full will result in processing delays and possible delay of payment

SECTION 1: PARTICIPANT INFORMATION

Participant Last Name	Participant First Name	Participant Middle Name	UID

Participant Preferred Phone Number	Email Address	Date of Birth

I do hereby attest that the information provided by me on this application is true, accurate, and complete to the best of my knowledge. I understand that it is fraudulent for me or anyone representing me to knowingly complete this application with false or misleading information or to knowingly omit important facts and that criminal and/or civil penalties can result from such acts.

X _____ _____

Signature of Participant or Authorized Representative **Date**

SECTION 2: TO BE COMPLETED BY PARTICIPANT'S ATTENDING PHYSICIAN

Patient Full Name	Patient BCBSIL ID	Patient DOB

Attending Physician Full Name	Specialty / Credentials

Mailing Address	City	State	Zip

Office Phone Number	Office Fax Number	Tax ID Number

Nature of disability (describe complications, if any)

Report of services. Include dates of service since initial period of disability, or the last Recertification period.

Date of Service	Location of Service	Description of Surgical or Medical Services Rendered	**Procedure Code** (if used) If CPT not used, give name

Patient has been **totally disabled** during the period: (unable to perform any duties of occupation)	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)
Patient has been **partially disabled** during the period: (unable to perform any duties of occupation)	Start Date (MM/DD/YYYY)	End Date (MM/DD/YYYY)

Are you actively supervising the patient's care? ☐ Yes ☐ No	If **YES**, frequency of appointments: (e.g., 2x/week, 1x/month, etc.)	Last Appointment (MM/DD/YYYY)	Next Appointment (MM/DD/YYYY)

Has the patient been referred to other medical professionals? ☐ Yes ☐ No, if YES, complete the following:		
Referring Physician One	Specialty	Office Phone
Referring Physician Two	Specialty	Office Phone
Referring Physician Three	Specialty	Office Phone

Patient is able to return to work on: (MM/DD/YYYY)	☐ Return is with some restrictions (complete section below) ☐ Return is with no restrictions (check Heavy work activity in section below) ☐ Disability is permanent, patient will not return to work (skip section below)

Patient is <u>currently</u> able to complete:

☐ **HEAVY** work activity – no limitations of functional capacity.

☐ **MEDIUM** work activity – exerting force of 20-50 lbs. occasionally and/or 10-25 lbs. frequently and/or >0-10 lbs. constantly.

☐ **LIGHT** work activity – exerting force of up to 20 lbs. occasionally and/or up to 10 lbs. frequently.

☐ **SEDENTARY** work activity – moderate limitation of functional capacity; exerting force of up to 10 lbs. occasionally. Sedentary work involves sitting most of the time but may involve walking or standing for brief periods of time.

☐ **NO ABILITY TO WORK.** Patient is completely disabled. Severe limitation or functional capacity, incapable of minimum activity.

☐ **OTHER.** Please explain:

Do you anticipate a return to work without restrictions? ☐ Yes ☐ No	If YES, provide date (MM/DD/YYYY)

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X

Signature of Attending Physician **Date**

SECTION 3: CHECKLIST

BEFORE YOU SUBMIT YOUR CLAIM APPLICATION, please <u>check the following</u>:

☐ I have completed Part 1 <u>in full</u>, <u>legibly</u> using <u>blue or black ink</u>.

☐ My physician has completed Part 2 <u>in full</u>, including their <u>dated signature</u>.

Special circumstances:

☐ If your physician has indicated that you are able to perform **Light or Medium** duties but there is no light duty available to you, a <u>corroborating statement from your employer is required</u>.

Submit completed Disability Application with copies of all required documents:

- **MAIL**: 12 E. Erie, St., Chicago, IL 60611
- **DROP-OFF**: 12 E. Erie, St., Chicago, IL 60611 *or* 4979 Indiana Ave, Lisle, IL 60532
- **Email**: <u>submit@macbenefits.org</u>
- **Fax**: (312) 337-6496

Frequently Asked Questions (FAQs)

What is the typical timing on recertification requests? Generally, within 5-7 business days of the Plan's receipt of all documentation needed to process your Recertification Application, the Plan will evaluate the information provided on the form to continue your disability benefit. Disability checks are issued and mailed every Thursday.

How do I apply for further disability benefits if I am disabled beyond the period certified by my doctor? If you continue to remain disabled you will be required to complete another Recertification Application confirming that you continue to be under the care of a physician with verification from them that you continue to remain disabled. The Plan will send to you another recertification form when needed for completion. The Plan provides benefits for a maximum period of <u>52 weeks only</u>.

Additional Questions? Please contact the Health Fund at (312) 787-9455, option 3. A Participant Services Representative can assist you Monday through Friday between the hours of 8:00 a.m. and 4:30 p.m.