STATEMENT OF CLAIM – WEEKLY INDEMNITY

Instructions

1. Employee must complete *PART A*
2. Ask patient's physician to complete *PART B*
3. Return claim form to Reliable Contracting *Attn: HR*

RELIABLE CONTRACTING CO. INC.

2410 Evergreen Rd Suite 200 Gambrills MD 21054
Tel: 410-987-0313 Fax: 410-721-2571

PART A – Employee Information

Employee's name (first, middle, last)	Date of Birth	Employee Number

Address (street, city, sate, zip)	Phone:
☐ Mail Disability Check to the above address ☐ Hold check at office (available for pick-up after 2:00 pm on Friday)	Cell:

Reason for claim:	Was illness or accident work related?	If work related, have you filed a Worker's Compensation claim?
☐ Illness ☐ Accident	☐ Yes ☐ No	☐ Yes ☐ No

If an Accident please provide the following information:

Date of accident:	Place accident took place:	How did it happen?

If an auto accident, please list auto insurance carrier name, policy # and carrier's phone number:

Auto Carrier Name: Policy# Phone number:

Date:	**Employee's Signature:**

AUTHORIZATION TO RELEASE INFORMATION

I AUTHORIZE any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc., consumer reporting agency, employer, or administrator having available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or my dependents and any other non-medical information of me to give my employer, administrator or plan administrator, Reliable Contracting Co. Inc, - Human Resources or it's legal representative, any and all such information.

I UNDERSTAND information obtained with this Authorization will be used by Reliable Contracting Co. Inc, - Human Resources to determine eligibility for coverage, and eligibility for benefits under an existing plan. Any information obtained will not be released by Reliable Contracting Co. Inc, Human Resources to any person or organization except to the plan administrator, my employer, administrator, reinsuring companies, the Medical Information Bureau, Inc. or other persons or organizations performing business or legal services in connection with the claim, or as it may be otherwise lawfully required or as I may further authorize. I KNOW that I may request to receive a copy of this Authorization.

I AGREE that a photographic copy of the Authorization shall be as valid as the original. I AGREE this Authorization shall be valid for two and one half years from the date shown below, or for the duration of this claim, if longer.

NOTICE: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

Date:	Employee's Signature:

PART B – Attending Physician's Statement

Nature of sickness or injury (Describe complications, if any).	ICD9 Code for sickness or injury.

Date and Nature of surgical or obstetrical procedure, if any. (If claim is due to pregnancy, give estimated date of delivery):

The patient has been continuously disabled (unable to work). From: Thru:	First date of treatment during this period of disability.
Have you discharged the patient? ☐ Yes ☐ No If yes, give date	If yes, any restrictions?
If still disabled, when should patient be able to return to work?	Next evaluation date.

If patient was referred to specialist, please list the name, address and telephone number of the specialist.

Name: Address: Phone:

Dr's Name _____
(Please Print)

Address _____
Street

_____
City State Zip

Phone Number _____

Signed _____Degree

Date _____