Trustmark
benefits beyond benefits

Disability Benefits Claim

For Claims Customer Service: ☎ **Phone:** (877) 201-9373 x45708
For Claims Submission: 🖷 **Fax:** (508) 853-2757 ✉ **Email:** DICIClaimsVB@trustmarkbenefits.com

Name of patient: _____ Date of Birth: ____/____/____

Attending Physician Statement (Page 1 of 2) *(To be completed by the physician)*

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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Date patient ***1st reported symptoms*** or accident happened: _____

Date patient ***advised to stop working*** because of impairment: _____

Date of 1st treatment: _____ Date of subsequent treatments: _____, _____,_____

Is this condition due to: An Accident? ❑ A Sickness? ❑ A Pregnancy? ❑

Is the accident or sickness related to the patient's employment? Yes ❑ No ❑ Unknown ❑

If condition due to Pregnancy: Est. Date of Delivery: _____ Actual Delivery Date: _____

Delivery Type: Vaginal ❑ C-Section ❑ If C-Section: Elective ❑ Non-Elective ❑

Did another physician refer this patient to you? Yes ❑ No ❑ If yes, please list name, address & specialty below:

_____
Physician Name Address Dates

Patient's Condition Date of initial assessment: _____ Current work status: _____

Primary DX causing impairment: _____ ICD 10 Code: _____

Contributing DX's: _____

Have you treated this patient for related conditions in the past? Yes ☐ No ☐ If Yes, describe intervention/timeframe and outcome: _____

Has patient been hospital confined? Yes ☐ No ☐ From: _____ To: _____

If Yes, Hospital Name: _____

Is patient able to do some work, but cannot work more than 50% of their regularly scheduled job? Yes ☐ No ☐
If yes, for what period of time do these restrictions limit the patient? From: _____ To: _____

I) **Impairment** Describe objective evidence for loss of physiologic, mental or anatomic function. Include pertinent results of physical exam & diagnostics:

_____

_____

_____

II) **Restrictions** (activities patient should not perform) and **Limitations** (activities patient cannot perform) based on documented **impairment(s)**:

_____

_____

_____

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Attending Physician Statement (Page 2 of 2) *(To be completed by the physician)*

III) **Disability** Based on my answers to section I & II above, my knowledge of the physical & mental requirements of my patient's job, and my knowledge & experience as a provider, I certify:

☐ 1) Total inabliity to work from _____ to _____ with a prognosis to return to work on _____ **OR**

☐ 2) Partial inabliity to work from _____ to _____ with a prognosis to return to work on _____ **OR**

☐ 3) I refrain from making a certification regarding work capacity at this time.

IV) **Additional Comments:**

_____

_____

_____

FRAUD NOTICE: Any person who knowingly files a statement of claim containing false or misleading information is subject to criminal and civil penalties. This includes Employer and Attending Physician portions of the claim form.

Physician's Name: (please print): _____

Specialty: _____

Address: _____

Phone: (____) _____ Fax: (____) _____

Signature: _____ Date Signed: _____

Please provide name & phone number for Office Manager or other person to contact if additional information is needed:
Name: (please print): _____ Phone: (____) _____

Please attach copies of all medical records relating to the claim condition including treatment notes & test results.
May we communicate with you using email? Yes ☐ No ☐ Email Address: _____