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 *(To be completed by the physician)*

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 Primary diagnosis: _____ ICD 10 Code: _____

Objective evidence supporting impairment (including X-rays, EKG's, lab data, physical exam notes, etc.)

_____

Limitation(s) or recommendation(s) related to impairment: _____

_____

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: _____

Do/Did you consider the patient to be completely unable to work in his/her occupation? Yes ❑ No ❑

If yes, please provide dates: From: _____ To: _____

If still completely unable to work, when do you expect patient will be able to return to his/her work duties?

1-3 mos. ❑ 3-6 mos. ❑ 6-12 mos. ❑ More than 12 mos. ❑

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: _____

Describe work restrictions: _____

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 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: _____