TO BE COMPLETED BY EMPLOYEE ONLY IF TIME LOSS IS INVOLVED

☐ RESUMED WORK
☐ EXPECTED TO RESUME
☐ TERMINATED

WAS THIS DISABILITY DUE TO OCCUPATIONAL CAUSE OR CAUSES? ☐ NO ☐ YES
EMPLOYEE PLEASE SIGN AND DATE

First full day unable to work _____ Date _____

Signature _____ Date _____

PATIENT & INSURED (SUBSCRIBER) INFORMATION

LOCAL UNION NO.

1. PATIENT'S NAME (First name, middle initial, last name)	2. PATIENT'S DATE OF BIRTH	3.
4. PATIENT'S ADDRESS (Street, city, state, ZIP code)		5. INSURED'S SOCIAL SECURITY NO.
		6. INSURED'S GROUP NO. *(Or Group Name)*
7. OTHER HEALTH INSURANCE COVERAGE - *Enter name of Policyholder and Plan Name and Address and Policy or Medical Assistance Number.*	8. WAS CONDITION RELATED TO **A.** PATIENT'S EMPLOYMENT ☐ YES ☐ NO **B.** AN AUTO ACCIDENT ☐ YES ☐ NO	9. COMPLETE ONLY IF ACCIDENT INVOLVED Date of accident _____ hour (am-pm) _____ Where did the accident occur? _____ *DESCRIBE THE ACCIDENT FULLY*
10. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE *(Authorize the Release of any Medical Information Necessary to Process this Claim)* SIGNED _____ DATE _____		

PHYSICIAN OR SUPPLIER INFORMATION

11. DATE OF	ILLNESS (FIRST SYMPTOM) *OR* INJURY (ACCIDENT) *OR* PREGNANCY (LMP)	12. DATE FIRST CONSULTED YOU FOR THIS CONDITION	13. HAS PATIENT EVER HAD SAME OR SIMILAR SYMPTOMS? ☐ YES ☐ NO
14. DATE PATIENT ABLE TO RETURN TO WORK	15. DATES OF TOTAL DISABILITY FROM	ESTIMATE THROUGH	
16. NAME OF REFERRING PHYSICIAN		17. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____	

18. NAME & ADDRESS OF FACILITY WHERE SERVICES RENDERED *(If other than home or office)*

19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. ***RELATE DIAGNOSIS TO PROCEDURE BY REFERENCE TO NUMBERS 1,2, 3, ETC. OR DX CODE***

1.
2.
3.
4.

SIGNED DATE	YOUR SOCIAL SECURITY NO.	20. PHYSICIAN'S OR SUPPLIER'S NAME, ADDRESS, ZIP CODE & TELEPHONE NUMBER
21. YOUR PATIENT'S ACCOUNT NO.	YOUR EMPLOYER I.D. NO.	I.D. NO.

IMPORTANT REMINDER

Please be sure you have provided the employee's Social Security Number and Local Union Number

GIVE THE COMPLETED "BENEFIT REQUEST FORM" AND THE BILLS TO:

Zenith American Solutions
2001 West Camelback Rd. #350
P.O. Box 16200
Phoenix, AZ 85011-6200
Phone: 602-264-1804

DISABILITY - CLAIM REPORT