



WEEKLY DISABILITY CLAIM FORM - RECERTIFICATION
CLAIM NO. _____

(Print Clearly)

Instructions: The participant must complete Part 1. The attending physician must complete Part 2. Return the completed form (by mail or fax) to the Fund Office. If you fax, please mail the original to the Fund Office. Failure to complete this form in full may result in a delay of payment.

Part 1 – To be completed by Participant							
1. Participant's Last Name First Middle Initial			2. Date of Birth / /		3. Soc. Sec. Number or BCBS I.D. Number		
4. Participant's Home Address				5. City		6. State	7. Zip Code
8. Telephone Number ()		9. Cell Phone Number ()		10. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		11. Email Address	
12. If you have been treated by physicians other than the one completing this form, please provide their names and phone numbers below:							
12(a) Name:					Phone Number: ()		
12(b) Name:					Phone Number: ()		
I hereby authorize any physician, hospital or other medical provider to release to the Chicago Regional Council of Carpenters Welfare Fund (the "Welfare Fund"), or its representatives, any information regarding my health, including but not limited to medical history, medical records from another provider, diagnosis, prognosis, symptoms and treatment of any physical or mental condition relevant to this application. I understand that the Welfare Fund will use this information to determine my claim for benefits. Information includes written, electronic and oral information related to this claim for benefits. Any information received by the Welfare Fund pursuant to this authorization shall be maintained in accordance with applicable privacy laws. This authorization shall expire at the later of (i) one year from the date of your signature or (ii) termination of the period in which you are eligible for Weekly Disability benefits. You have the right to revoke this authorization at any time. A photographic copy of this authorization shall be as valid as the original. I understand that it is fraudulent for me or anyone to knowingly complete this form with false or misleading information or to knowingly omit important facts.							
(Claim not valid unless signed by Participant)							
13. Participant's Signature X						Date: / /	
Part 2 – To be completed by Attending Physician							
1. Patient's Name (Last) (First) (Middle Initial)			2. Patient's Soc. Sec. Number or BCBS I.D. Number		3. Patient's Date of Birth / /		
4. Nature of sickness or injury (describe complications, if any)							
5. Report of Services (If you have submitted a previous form for this patient, you need only show dates and service since last report.)							
Date of Services	Place of Service	Description of Surgical or Medical Services Rendered				Procedure Code . If Used (If code other than CPT used, give name)	
6. Patient was continuously totally disabled (unable to perform duties of occupation) from: <input type="checkbox"/> n/a or / / through / /				7. Patient was continuously partially disabled from: <input type="checkbox"/> n/a or / / through / /			
8. Please state whether you are actively supervising the patient's care and, if so, the frequency of visits (e.g., weekly, monthly)							
9. If patient was partially disabled, please list restrictions, including weight restrictions:							
10. Date Patient is able to return to work: / /							
11. Attending Physician's Name:					12. Phone Number: ()		13. Fax Number: ()
14. Attending Physician's Address			15. City		16. State	17. Zip	
18. Signature of Physician			19. Physician's Tax Identification Number		20. Date Completed / /		