Triada Health

10713 W. Sam Houston N. Suite 100 Houston, TX 77064
Fax both pages of this form to: (281)-741-1830

For your protection California law requires the following to appear on this form: Any Person who knowingly presents a false or fraudulent claim payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

FULL NAME:		E-MAIL ADDRESS:	
LIST OTHER NAMES, SUCH AS NICKNAME:		HOME PHONE	BUSINESS PHONE
MAILING ADDRESS (Street, City, State, Zip)		POLICY NUMBERS a) b) c)	PLAN NUMBERS a) b) c)
BIRTHDATE (XX/XX/XXXX)	HEIGHT / WEIGHT		LAST PAYMENT DATE a) b) c)
Is claimant eligible for Medicaid or similar state program? ☐YES ☐NO			
OCCUPATION	**CCPOA Benefit Trust Fund**	ARE YOU ALSO FILING A CLAIM UNDER WORKERS' COMP. ACT? ☐YES ☐NO	
IF YOU HAVE OTHER ACCIDENT, SICKNESS, OR HOSPITAL INSURANCE, GIVE COMPANY NAME:			
IF CLAIM IS FOR **SICKNESS** PLEASE COMPLETE	DATE OF FIRST SYMPTOMS (XX/XX/XXXX)	HAVE YOU EVER HAD THE SAME OR A SIMILAR CONDITION? IF YES GIVE DATE (XX/XX/XXXX) ☐YES ☐NO DATE:	
	NATURE OF THE SICKNESS		
IF CLAIM IS FOR **ACCIDENTAL INJURY** ("ACCIDENT") PLEASE COMPLETE	DATE OF ACCIDENT (XX/XX/XXXX)	TIME OF ACCIDENT (AM OR PM)	NATURE OF INJURIES
	PLEASE STATE EXACTLY WHERE YOU WERE WHEN ACCIDENT OCCURRED, INCLUDING A DETAILED DESCRIPTION OF HOW ACCIDENT OCCURRED		
PLEASE COMPLETE FOR BOTH **ACCIDENT AND SICKNESS** CLAIMS	HOSPITAL NAME	HOSPITAL ADDRESS, CITY, AND STATE	CONFINEMENT DATES(XX/XX/XXXX) (from – to)
	ATTENDING PHYSICIAN'S NAME AND ADDRESS		DATES OF TREATMENT 1) 2)
	A) **TOTAL DISABILITY**: BETWEEN WHAT DATES WERE YOU UNABLE TO PERFORM ANY DUTIES(XX/XX/XXXX)?		A) FROM: THROUGH:
	B) DATE RETURNED BACK TO WORK (XX/XX/XXXX)		B) DATE:
	C) **PARTIAL DISABILITY**: BETWEEN WHAT DATES WERE YOU ABLE TO PERFORM ONLY PARTIAL DUTIES?		C) FROM: THROUGH:

EMPLOYERS STATEMENT (if student, please have school principal complete) **COMPLETE ONLY IF CLAIMING LOSS OF TIME**

EMPLOYER'S FULL NAME		WORKERS' COMPENSATION CLAIM FILED FOR THIS DISABILITY? ☐YES ☐NO
NAME AND ADDRESS OF COMPENSATION CARRIER		DATE RETURNED TO WORK OR SCHOOL(XX/XX/XXXX)
TOTAL DISABILITY: BETWEEN WHAT DATES DID EMPLOYEE GIVE UP ALL DUTIES?	FROM: TO:	**PARTIAL DISABILITY:** BETWEEN WHAT DATES DID EMPLOYEE GIVE UP ONLY PART OF DUTIES — FROM: TO:
DATE:	TITLE: EMPLOYER SIGNATURE	PHONE NUMBER XXX-XXX-XXXX

AUTHORIZATION TO RELEASE INFORMATION

I authorize any hospital, medical practitioner, medically related facility, Prescription drug database, insurance company, state and federal government agency, the Internal Revenue Service, employer, consumer reporting agency or the MIB to release to Triada Health any information for the purpose of processing a claim. Triada is also authorized to disclose such information to any doctor. This authorization or photocopy shall be valid for the duration of the claim. A copy is available upon request.

DATED SIGNED

ATTENDING PHYSICIAN'S STATEMENT	
PATIENTS NAME	ADDRESS (street, city, state, zip)
1. NATURE AND ORGIN OF: ☐SICKNESS ☐INJURY	**DIAGNOSIS (**describe complications, if any) CONFIRMED BY XRAY: ☐YES ☐NO
2. WHEN DID SYMPTOMS FIRST APPEAR OR ACCIDENT HAPPEN?	DATE:
3. WHEN DID PATIENT FIRST CONSULT YOU?	DATE:
4. HOW DID CONDITION ORGINATE	
5. HAS PATIENT EVER HAD SAME OR SIMILAR CONDITION?	☐YES ☐NO IF YES, DESCRIBE:
6. DESCRIBE ANY OTHER DISEASE OR INFIRMITY AFFECTING PRESENT CONDITION	
7. GIVE DATE AND NATURE OF SURGICAL OR OBSTETRICAL PROCEDURE, IF ANY. (DESCIBE FULLY AND GIVE APPROACH USED IF MORE THAN ONE IS POSSIBLE.)	DATE: NATURE OF PROCEDURE: APPROACH USED: ☐CLOSED REDUCTION ☐OPEN REDUCTION ☐METAL FLEXATION
8. GIVE DATE OF TREATMENT, AND NATURE OF TREATMENT OTHER THAN SURGICAL	DATE: NATURE OF TREATMENT: ☐OFFICE ☐HOSPITAL ☐HOME
9. IS PATIENT STILL UNDER YOUR CARE FOR THIS CONDITION? IF DISCHARGED, GIVE DATE, AND DEGREE OF RECOVERY.	☐YES ☐NO DISCHARGE DATE: RECOVERED? ☐YES ☐NO
10. IF PATIENT HOSPITALIZED, GIVE NAME AND ADDRESS OF HOSPITAL	HOSPITAL: ADDRESS (address, city, state, zip): FROM: THROUGH:
11. HOW LONG WAS OR WILL PATIENT BE CONTINUOUSLY TOTALLY DISABLED?	FROM: THROUGH:
12. HOW LONG WAS OR WILL PATIENT BE PARTIALLY DISABLED?	FROM: THROUGH:
13. IF PATIENT IS DISABLED ON DATE YOU COMPLETE THIS FORM, IS THERE A RETURN TO WORK DATE?	☐YES ☐NO RETURN TO WORK DATE:

PHYSICIANS SIGNATURE	PHYSICIANS DEGREE
COMPLETE ADDRESS: (address, city, state, zip)	
DATE	PHONE NUMBER
MUST BE FURNISHED UNDER AUTHORITY OF SECTION 6109 OF THE IRS CODE	
INDIVIDUAL PRACTITIONER'S S.S NUMBER	ALL OTHERS – EMPLOYER ID NUMBER