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N. Charleston, SC 29406
Phone: 843-797-5050
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DISABILITY FORM PROTOCOL

Lowcountry Orthopaedics & Sports Medicine a member of Arcis Healthcare, L.L.C. has developed a standard form for disability benefits that will be sent to your disability carrier.

ALL forms (disability, FMLA, loan, out-of-work, etc.) are completed in the order in which they are received, after the chart and medical records are made available. There are approximately 15 forms submitted each day. Therefore, it may not be possible to complete the forms immediately. We ATTEMPT to complete the forms within a reasonable time frame; however you must be made aware that we will not always be able to complete your form before the deadline.

Please read and complete the *Disability Benefits/ FMLA Authorization* form in its entirety. **A $15.00 processing fee applies to each form request** payable at any of our office locations, by Patient Portal, or by phone by calling 843-793-6753. Payment must be made before the form will be processed. After the first form has been completed, all patient account balances must be paid *and kept current* before any additional disability form will be completed.

Fax: 843-797-3633
Attn: Adrienne F. / M.R. Dept Rep.

For questions, please leave a voice message at the telephone number:
843-793-6753.

Please allow five to ten business days for the form to be completed.

MR#: ___________________

DISABILITY BENEFITS / FMLA AUTHORIZATION

NOTICE: Please allow up to 10 business days for your request to be completed in light of the large volume of requests we receive weekly**. A processing fee of $15.00 per form request is due prior to completion.** While we do not complete specific *disability* forms from individual carriers, we will provide a standard statement that will include all information necessary for the carrier to process your claim.

Patient Name:	**Date of Birth:**
Social Security Number:	**Telephone Number:**
Treating Physician:	**Email Address:**

Did the injury happen at work? YES NO

Is the patient attending PT? YES NO

List the name, claim number if you have it, and fax number where your forms should be sent (NOTE: FMLAs may not have claim numbers.):
Name:
Claim #:
Fax:

We suggest all forms be faxed for recording purposes, but you may choose to pick up a copy of your form at any of our office locations for no additional charge. For patients living out of the area or who have transportation issues we will gladly mail the copy to your home address.

I authorize Lowcountry Orthopaedics and Sports Medicine a member of Arcis Healthcare, L.L.C. to release all information requested by my insurance company for the processing of my disability claim. I acknowledge this form is valid for one year from the date I sign and may be revoked at any time by providing written notice to our Medical Records/ Legal Department.

Signature: ______________________________ *Date:* ____________________

Please remember to ask your doctor to address your work status or any restrictions at every visit.