I.B.E.W. 292 Health Care Plan

Loss of Time Application
Health Care Provider Continuation Form

It is the responsibility of the member to see that all sections of this form are complete, questions answered and the form returned to the plan office at **6900 Wedgwood Road N., Suite 425, Maple Grove, MN 55311, Ph. (763) 493-8830 or (800) 368-9045 Fax (763) 416-6196 or via email to claiminfo@ibew292benefits.com.**

For applications related to Mental Health and Chemical Dependency, TEAM serves as case manager and will make final decisions regarding these benefits.

Please Type or Print

1. Patient's Name ______________________________
2. Patient's Date of Birth ______________________________
3. Name of illness/injury/diagnosis ______________________________
4. Was patient confined to a hospital or care suite overnight? ______________________________
5. Surgical procedures, if any,________________ Date performed ________________________
6. Date patient first consulted you for this condition ______________________________
7. Is the patient still under your care for this condition? If yes, date of most recent treatment.

   ____
8. Frequency of treatment(s) ______________________________
9. If pregnancy, please give delivery date ______________________________
10. Date employee first unable to work due to illness/injury/diagnosis? ____________________
11. Is the employee now, and has the employee been, unable to perform all of the essential functions of their job from the date of onset of the illness/injury/diagnosis identified above?

    Yes _____ No ______ Remarks, if any ______________________________
12. Describe the current treatment plan, including goals or objectives of treatment, planned interventions, and estimated timeline. ______________________________
    ____
13. When will the employee be able to return to work? (Give approximate date) ______________
14. If the employee can return with restrictions, please describe the restrictions in detail.

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15. When will the employee be able to return to work without restrictions? (Give approximate date)

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16. In your opinion, is the employee unable to perform all of the essential functions of their job as a result of illness or injury arising out of or in the course of employment: Yes ___ No ___

If yes, please explain ____

17. Remarks and any additional health care provider's notes to support the request. _________

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It is the member's responsibility to provide all medical records and notes, from all treating health care providers, for all appointments that have occurred since the date of the illness/injury/diagnosis identified above in response to Question 3.

Date signed _________________

Health Care Provider's Signature ____

Health Care Provider's Name ____

Address ____

Phone number ____

Health Care Provider I.D. or NPI Number ____

I hereby authorize release of medical information to I.B.E.W. 292 Health Care Plan to receive Loss of Time Benefits and do certify that the above statement is true. I also authorize release of workability to the International Brotherhood of Electrical Workers Local Union No. 292 Hiring Hall.

Employee's Name ____

Employee Signature ____