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

Loss of Time Application – to be completed by a Health Care Provider

It is the responsibility of the member to see that all sections of this form are complete, questions answered, necessary medical records and doctor's notes provided, 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 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. Patients 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 injury/illness/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 identified in response to Question 6?

    Yes _____ No _____ Remarks, if any ______________________________

12. Describe the current treatment plan, including the goals or objectives of treatment, planned interventions, and estimated timeline. ______________________________

    ____

13. When will the employee be able to return to work with restrictions? (Give approximate date)

    ____

14. If the employee can return with restrictions, please describe the restrictions in detail.____________

____

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

____

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. _______________

____

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 Signature _______________

Health care provider Name _________________

Address ___________________________________

____

____

____

Send Medical Records

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.

Date. ________________________ Employee's Signature _____________________________________