 **Disability/FMLA Request** 

Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Disability Forms ($25) FMLA Forms ($25) Other Type ($25) Auto/Work Comp

Ciox is a third party vendor for OAM & RVO that is pleased to assist you in completing your Disability and FMLA paperwork. **Be advised there is a 7-10 business days processing time frame once all information and payment is obtained.**  We understand you may have an urgent deadline for your paperwork and we will do our best to accommodate this. However, all paperwork will be processed in the order that it is received. By law, we are required to have you provide us with a signed authorization which gives us permission to disclose your personal health information, which also serves as a guide of where to submit your paperwork. By completing this form, you are authorizing disclosure of your private health information.

Patient Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Day Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OK to Leave a Detailed Phone Message? □ Yes □ No E-Mail Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

USED TO PROVIDE STATUS UPDATES

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Release Completed Paperwork To:**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I authorize Orthopaedic Associates of Michigan & River Valley Orthopedics to provide charts, notes, x-rays, operative reports, lab and medication records and all other medical information about me, including medical history, diagnosis, testing, test results, prognosis and treatment of any physical or mental condition.
* I understand this may include: any disorder of the immune system, including HIV, AIDS or other related syndromes or complexes; any communicable disease or disorder; any psychiatric or psychological condition; any condition, treatment, or therapy related to substance abuse; and any non-medical information requested about me, including things such as education, employment history, earnings or finances, return to work accommodation discussions or evaluations and eligibility for other benefits or leave periods including but not limited to claims status, benefit amount, payments, settlement terms, effective and termination dates, plan or program contributions.
* I also acknowledge I am responsible to pay the paperwork completion fee prior to its completion.
* This authorization will expire one year from the date signed, unless an earlier termination date is specified. A new authorization must be submitted after the expiration date to continue authorization. *Please list date of expiration if less than 1 year*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* You have the right to revoke or terminate this authorization at any time by submitting a written request. Termination will take place upon written notice except where a prior authorization has been made based on prior authorization.
* The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
* We have not control over the recipient listed to receive your protected health information. Therefore, your PHI disclosed under this authorization may no longer be the responsibility of the practice.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient or Legal Representative Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name Relationship

*Office Use Only: \_\_\_\_\_\_\_\_\_Received By Initials*

*Payment Collected N/A Approval of RVO Form Completion \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*(7/2018)*

 

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Grand Rapids, MI 49525 Grand Rapids, MI 49503

Ph 616-459-7101 Ph 616-456-8515

Fax 616-336-5042 Fax 616-456-8208

**Disability Insurance/FMLA Instructions**

1. Contact Your Human Resources Department

Obtain the necessary paperwork from your HR Department or Disability Company**. It is the patient’s**

**responsibility to get the paperwork for completion to our Medical Records Department** at one of the sites listed above.

1. Authorization Form is Required

Once you have obtained the paperwork, you need to complete a “Disability/FMLA Request” authorization which is required for each request recipient and will be good for one year unless otherwise stated in writing.

1. Cost per Request

OAM and RVO contract a 3rd party, Ciox, to complete any and all paperwork. **The cost to have Ciox process**

**your paperwork is $25 per request. This payment must accompany your Form Request and paperwork**

**before the completion process can be initiated.**

***Make Checks Payable To:***

***Orthopaedic Associates of Michigan*** *OR* ***River Valley Orthopedics***

*Worker’s Compensation & Auto Claims will be billed directly to the insurance company at this time.*

1. Submit Your Paperwork for Completion

Submit the paperwork, the Form Request, and the $25 payment for each request needed to be processed.

It will take approximately 7-10 business days for the paperwork to get completed and submitted.

1. Follow Up with Your Employer

Approximately 7-10 business days after submitting the paperwork for completion, follow up with your HR Department or Insurance Company to ensure that they have received your completed paperwork.

1. Status of Forms

If you need to check on the status of your paperwork, please call the appropriate phone # listed above and ask for Medical Records Forms Status.