

**WOMEN FIRST OF LOUISVILLE, PLLC
GYNECOLOGICAL DISABILITY CLAIM FORM**



DISABILITY CARRIER: Please note that this Standard Disability Claim Form is the only form we will complete without charge. We will provide this service once, per disability incident. Carriers who insist that any other form be completed will incur our customary charge of \$30.00, payable in advance. We request your patience for completion of any necessary disability claim forms.

STANDARD DISABILITY CLAIM FORM

Patient: _____ SS# _____

Diagnosis: _____

Date first seen for this Disability: _____

Dates of Disability: From: _____ To: _____

Return to Work date: _____ Related to employment: Yes _____ No _____

Explanation of any restrictions: _____

(No lifting, pushing or pulling weight greater than 25 pounds)

Regimen of treatment prescribed: _____

Physician Signature _____ Date _____

Tax ID No. 61-1314354