WOMEN FIRST OF LOUISVILLE, PLLC
OBSTETRICAL DISABILITY CLAIM FORM

Women First of Louisville, PLLC
Obstetrics & Gynecology

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 of Initial Visit: _____ Date of Last Visit: _____

LMP Date: _____ EDD Date: _____

Dates of Disability: From: _____ To: _____
(6 weeks after for a vaginal delivery or 8 weeks after for a Cesarean delivery.)

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

Women First of Louisville PLLC
3900 Kresge Way, Ste. 30 • Louisville, KY 40207
Phone (502) 891-8700 • Fax (502) 891-8752