HEALTHMARK GROUP

MIDWEST ORTHOPÆDIC CENTER

FMLA / DISABILITY FORM COMPLETION INTAKE FORM

INSTRUCTIONS:

Complete and submit this form with your FMLA/Disability paperwork to your physician's office. **Incomplete forms will delay processing.** Your documents will be sent to HealthMark Group. You will receive an invoice via email once completed.

PATIENT INFORMATION

Today's date: _____

Patient name: _____ Date of birth: _____

Patient email: _____ Patient phone: _____

FMLA / DISABILITY FORM INFORMATION

☐ FMLA request ☐ Disability Request

IF FMLA:

☐ Continuous (a continuous period of time) ☐ Intermittent (off and on)

CAREGIVER FMLA:

☐ Yes ☐ N/A

CAREGIVER FMLA TYPE:

Caregiver's name: _____

☐ Continuous (a continuous period of time) ☐ Intermittent (off and on)

LEAVE INFORMATION

Starting date of leave: _____ ☐ N/A or Retired

Estimated ending date of leave: _____ Estimated return to work date: _____

SURGERY INFORMATION:

Have you had surgery/procedure?

☐ Yes ☐ N/A

If yes, date of surgery/procedure? _____ Inpatient/outpatient? _____

Name/type of surgery/procedure: _____

HOSPITALIZATION INFORMATION:

Have you been hospitalized?

☐ Yes ☐ N/A

If yes, Date of admission: _____ Date of discharge: _____

Hospital name/location: _____

ADDITIONAL DETAILS

Please provide any other information that may help HealthMark Group complete your forms:

_____

_____

_____

THIRD PARTY INFORMATION *(Where to forward completed forms after processing fees are paid.)*

Send directly to patient: ☐

Business name: _____

Fax: _____

AUTHORIZATION AND ACKNOWLEDGEMENT

☐ I understand there are processing fees for form completions services, charged per form.

FMLA: $35.00 | Disability: $35.00 | Updates: $10.00 | Expediting $15.00

☐ By signing below, I authorize HealthMark Group to release my form(s) to the party listed above.

Patient Signature: _____ Date: _____

For questions contact HealthMark Group directly. Email: fmla@healthmark-group.com | Call: 800-659-4035