Incapacitation Form

Patient Information – To be Completed by Member/Patient or Subscriber/Legal Guardian

Member Name____ DOB__________ ID Number______________

Subscriber Name & ID____ Plan Name__________________

Statement of Incapacitation – To be Completed by the Member/Patient's Physican

Provider's Name____ Provider's Phone Number______________

Provider's Full Address____

Provider's Tax ID Number____

Date Patient Was Last Examined by Physician _____________________

Nature of Condition Causing Incapacity:

☐ Developmental Disability ☐ Medical Disability ☐ Mental Disorder

☐ Other (Please Explain) ____

Incapacitation is: ☐ Complete ☐ Partial - ______% Incapacitated

Incapacitation is: ☐ Temporary (Estimated Duration is) ____________________________________

☐ Permanent

At what age did the patient become incapacitated? ____

Diagnosis of Condition Causing Incapacity: Please give as much detail as possible, including dates of surgery, forward laboratory data and results of special tests, such as x-rays, EKGs, EEGs, etc. Attach additional pages as necessary.

Diagnosis

Comments to Support Incapacity

Is patient or will patient be able to self-support? ☐ Yes ☐ No

If yes, from ____

Is patient able to perform full or part-time work of any kind? ☐ Yes ☐ No

Has patient previously been able to perform full or part-time work of any kind? ☐ Yes ☐ No

Does patient have a job? ☐ Yes ☐ No ☐ Unknown

Do you know what duties the patient's job requires? ☐ Yes ☐ No

If yes, please explain: ____

Physican's Name (Printed) ____________________ Physican's Credentials ____________________

Physician Signature ______________________________ Date______________

Submit this completed form to UMFax@healthcomp.com with encryption for security. You can also fax this completed form to 1-559-243-7012.