NORTHLAND WOMEN'S HEALTH CARE, P.C.
OBSTETRICS / GYNECOLOGY

PATIENT DISABILITY/ INSURANCE CLAIM FORM

* = required fields

Please allow a maximum of 2 weeks for forms to be completed. There is a $20.00 fee per form.
Please answer the following questions and attach this to your form(s)

Note: If your form(s) is/are for Pregnancy, please be aware that standard time off is 6 weeks following a vaginal delivery, and 8 weeks following a C-Section. If you are planning on taking more time off – before or after your Delivery – please indicate this on Question 7 and include the reason(s).

1. Date _____
2. Name of Patient *
3. Patient's Date of Birth *
4. Patient's daytime phone number (where you can be reached in case of questions) _____
5. Reason for Claim: ◯ Pregnancy ◯ Surgery ◯ Other _____
6. Who is this form for? ◯ Yourself ◯ Husband
7. What is the first planned day of leave? _____
8. What is the return date? _____
9. How long will the total leave be (weeks)? _____

If this is not the standard time off (as outlined above), please give your reason(s)

Has this been discussed with your doctor? ◯ Yes ◯ No

10. Will you return from leave on "regular" duties? ◯ Yes ◯ No

If No, what type of restrictions apply? _____

11. When this form is completed, which would you like us to do?

◯ Give to Front Desk Staff for you to pick up in 2 weeks

◯ Call you – provide a phone number _____

◯ Mail it to: Name _____

_____ City _____ State ____ Zip _____

◯ Fax it to – provide a fax number _____

Additional Notes (if needed)

Attach the appropriate files (if applicable)