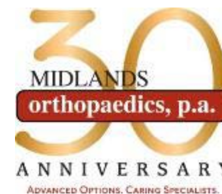
MIDLANDS ORTHOPAEDICS, PA (MOPA)
1910 Blanding Street, Columbia, SC 29201
(Ph) 803.256.4107x6139 * (Fax) 803.933.6317



Disability Form Protocol

Midlands Orthopaedics, PA has developed a standard form for disability benefits that will be sent to your disability carrier.

A $20.00 processing fee applies to each form request; and a $10.00 fee applies to each request for an update to a previously completed request. Any front desk employee at any of our locations can accept this payment from you.

Payment must be remitted before the form will be processed.

Please read and complete the ***Claimant Information for Disability Benefits*** form in its entirety. You may submit the completed form and payment to any front desk staff member, or you may mail the completed form and payment by check to the following address:

Midlands Orthopaedics, PA
Attn: Disability Benefits
1910 Blanding Street
Columbia, SC 29201

Please allow up to ten days for the form to be completed.

You may submit questions related to the status of your request via our secure, electronic portal by clicking on the Patient Portal link of our website, www.midlandsortho.com; or by leaving a message at the following number: 803.256.4107 x 6139.

CLAIMANT INFORMATION FOR DISABILITY BENEFITS

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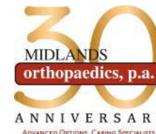

Please provide the following information to request documentation to submit with a claim for short or long term disability benefits. While we do not complete specific forms from individual carriers, we will provide a standard statement that will include all information necessary for the carrier to process your claim. We will strive to complete your form as quickly as possible; however, please allow up to 10 days for your request to be completed in light of the large volume of requests we receive weekly. A processing fee of $20.00 per disability form request is due prior to completion. A fee of $10.00 per disability update request is due prior to completion.

Patient Name:

Social Security Number: Date of Birth:

Street Address:

City, State and Zip: Telephone:

Treating Physician:

I am seeking documentation of the diagnosis and treatment related to the following illness or injury. Include the location of the illness injury (for example, hip, knee, back):

Approximate date of first treatment by our provider(s) for this illness or injury:

Did the patient ever have the same or similar condition before?

Is this condition work related?

Please indicate if the patient has received any of the following procedures:

___ Inpatient Surgery ___Outpatient Surgery ___MRI ___Injection

Is the patient attending Physical Therapy?

List the name, address, and/or fax number where your forms should be sent:
Name:
Address:
City/State/Zip: Fax:

Are you willing to receive your completed form via a secure electronic portal?
If so, please include an email address so we can let you know when it is ready: ___________________________________

I authorize Midlands Orthopaedics, PA to release all information requested by my insurance company for the processing of my disability claim.

Signature: ____ *Date:* _________________________________