

Claim for Disability Insurance (DI) Benefits





250104121

Health Insurance Portability and Accountability Act (HIPAA) Authorization

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the California Unemployment Insurance Code.

I agree that photocopies of this authorization shall be as valid as the original.

I understand I have the right to revoke this authorization by sending written notification stopping this authorization to EDD, DI Branch MIC 29, PO Box 826880, Sacramento, CA 94280. The authorization will stop on the date my request is received. I understand that the consequences for my revoking this authorization may result in denial of further State Disability Insurance benefits.

I understand that, unless revoked by me in writing, this authorization is valid for fifteen years from the date received by EDD or the effective date of the claim, whichever is later. I understand that I may not revoke this authorization to avoid prosecution or to prevent EDD's recovery of monies to which it is legally entitled.

I understand that I am signing this authorization voluntarily and that payment or eligibility for my benefits will be affected if I do not sign this authorization. The consequences for my refusal to sign this authorization may result in an incomplete claim form that cannot be processed for payment of State Disability Insurance benefits.

I understand I have the right to receive a copy of this authorization.

Claimant Signature (Do Not Print)	D	ate	Si	gne	d			\neg
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Your disability claim can also be filed online at www.edd.ca.gov/

PLEASE PRINT WITH BLACK INK.

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PART A - CLAIMANT'S STATEMENT A1. YOUR SOCIAL SECURITY NUMBER A2. IF YOU HAVE PREVIOUSLY BEEN ASSIGNED AN EDD CUSTOMER ACCOUNT NUMBER, ENTER THAT NUMBER HERE A3. CALIFORNIA DRIVER LICENSE OR ID NUMBER A4. GENDER MALE FEMALE													
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A39	PLEASE REVIEW, SIGN, AND DATE ITEM A39, AND IF APPLICABLE, ITEMS A40 AND A41 A39. Declaration and Signature. By my signature on this claim statement, I claim benefits and certify that for the period covered by obtain payment of benefits is a violation of California law and that such violation is punishable by imprisonment or fine or both. I declare under penalty of perjury that the foregoing statement including any accompanying statement.																																											
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Claim for Disability Insurance (DI) Benefits - Physician/Practitioner's Certificate PLEASE PRINT WITH BLACK INK.





PART B - PHYSICIAN/PRACTITIONER'S CERTIFICATE B1. PATIENT'S SOCIAL SECURITY NUMBER B2. PATIENT'S FILE NUMBER													
B1. PATIENT'S SOCIAL SECURITY NUMBER B2. PATIENT'S FILE NUMBER													
B3. IF YOU KNOW THE PATIENT'S ELECTRONIC RECEIPT NUMBER, ENTER IT HERE: B4. PATIENT'S DATE OF BIRTH													
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B5. PATIENT'S NAME (FIRST) (MI) (LAST)													
B6. PHYSICIAN/PRACTITIONER'S LICENSE NUMBER B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED B7. STATE OR COUNTRY (IF NOT U.S.A.) THAT ISSUED LICENSE NUMBER ENTERED B7. STATE OR COUNTRY (IF NOT U	D IN R6												
STATE COUNTRY													
B8. PHYSICIAN/PRACTITIONER LICENSE TYPE B9. SPECIALTY (IF ANY)													
B10. PHYSICIAN/PRACTITIONER'S NAME AS SHOWN ON LICENSE (FIRST) (MI) (LAST)	SUFFIX												
	SOFFIX												
B11. PHYSICIAN/PRACTITIONER'S ADDRESS													
MAILING ADDRESS, PO BOX OR NUMBER/STREET/SUITE#													
CITY STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.	A.)												
COUNTY HOSPITAL/GOVERNMENT FACILITY ADDRESS													
FACILITY NAME (IF APPLICABLE)													
FACILITY ADDRESS, NUMBER/STREET/SUITE#													
CITY STATE ZIP OR POSTAL CODE COUNTRY (IF NOT U.S.	A.)												
P12. THIS DATIENT HAS DEEN LINDED MY CARE AND TREATMENT FOR THIS MEDICAL PROPERTY.													
B12. THIS PATIENT HAS BEEN UNDER MY CARE AND TREATMENT FOR THIS MEDICAL PROBLEM FROM M M D D Y Y Y Y TO M M D D Y Y Y Y Y CHECK HERE TO INDICATE YOU ARE STILL TREAT													
FROM M M D D Y Y Y Y TO M M D D Y Y Y Y Y CHECK HERE TO INDICATE YOU ARE STILL TREAT	ING THE PATIENT												
AT INTERVALS OF: DAILY WEEKLY MONTHLY AS NEEDED OTHER													
B13. AT ANY TIME DURING YOUR ATTENDANCE FOR THIS MEDICAL PROBLEM, HAS THE PATIENT BEEN INCAPABLE OF PERFORMING HIS/H OR CUSTOMARY WORK?	ER REGULAR												
YES - ENTER DATE DISABILITY BEGAN M M. D D Y Y Y Y	O B33												
WAS THE DISABILITY CALISED BY AN ACCIDENT OR TRAUMA?	9 000												
M M D D Y Y Y Y IFYES, INDICATE THE ACCIDENT OR TRAUMA OCCURRED.													
II TES, INDICATE THE DATE THE ACCIDENT ON TRACINA OCCURNED.													
B14. DATE YOU RELEASED OR ANTICIPATE RELEASING PATIENT TO RETURN TO HIS/HER REGULAR OR CUSTOMARY WORK													
("UNKNOWN", "INDEFINITE", ETC., NOT ACCEPTABLE.)													
CHECK HERE TO INDICATE PATIENT'S DISABILITY IS PERMANENT AND YOU NEVER ANTICIPATE RELEASING PATIENT TO RETURN TO	O HIS/HER												
REGULAR OR CUSTOMARY WORK													
B15. IF PATIENT IS NOW PREGNANT OR HAS BEEN PREGNANT, PLEASE CHECK THE APPROPRIATE BOX AND ENTER THE FOLLOWING:													
ESTIMATED DELIVERY DATE: M M D D V V V V D DATE PREGNANCY ENDED: M M D D	D Y Y Y Y												
TYPE OF DELIVERY, IF PATIENT HAS DELIVERED: VAGINAL CESAREAN													







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PART B - PHYSICIAN/PRACTITIONER'S CERTIFICATE - CONTINUED															
B25. PLEASE RE-ENTER PATIENT'S SOCIAL SECURITY NUMBER															
B26. WAS THE PATIENT SEEN PREVIOUSLY BY ANOTHER PHYSICIAN/PRA	CTITIONER OR MEDICAL FACILITY FOR THE CURRENT DISABILITY/ILLNESS/INJURY?														
YES NO UNKNOWN	IF YES, WHAT WAS THE DATE OF FIRST TREATMENT?														
B27. DATE AND TYPE OF SURGERY/PROCEDURE MOST RECENTLY PERF	ORMED OR TO BE PERFORMED														
M M D D Y X Y Y															
WAS THE PATIENT HAARIE TO WORK IN															
	MMEDIATELY PRIOR TO THE SURGERY OR PROCEDURE? YES NO														
IF YES, PLEASE PROVIDE THE FIRST DA	TE THE PATIENT WAS UNABLE TO WORK BEFORE THE SURGERY OR PROCEDURE														
B28. ICD PROCEDURE CODE(S) ICD-9 ICD-10															
CPT CODE(S) (DO NOT INCLUDE MODIFIERS)															
R29 WAS THIS DISABILING CONDITION CALISED AND/OR ACCRAVATED B	DV THE DATIFALTIS DECULIAR OF CHOTOMARY WORKS														
B29. WAS THIS DISABLING CONDITION CAUSED AND/OR AGGRAVATED BY THE PATIENT'S REGULAR OR CUSTOMARY WORK? YES NO															
B30. ARE YOU COMPLETING THIS FORM FOR THE SOLE PURPOSE OF RE	B30. ARE YOU COMPLETING THIS FORM FOR THE SOLE PURPOSE OF REFERRAL/RECOMMENDATION TO AN ALCOHOLIC RECOVERY HOME OR DRUG-FREE														
RESIDENTIAL FACILITY AS INDICATED BY THE PATIENT IN QUESTION	N A30?														
B31. DATE YOUR PATIENT BECAME A RESIDENT OF A DRUG OR ALCOHOL	FACILITY (IF KNOWN)														
B32. WOULD DISCLOSURE OF THE INFORMATION ON THIS FORM BE MEDIC	CALLY OR PSYCHOLOGICALLY DETRIMENTAL TO YOUR PATIENT? YES NO														
B33. ALL PERSONS AUTHORIZED TO CERTIFY (REQUIRED) (CHECK ONE)															
	EON, CHIROPRACTOR, DENTIST, PODIATRIST, OPTOMETRIST OR PSYCHOLOGIST) ABLE TO PERFORM HIS/HER REGULAR OR CUSTOMARY WORK BECAUSE OF														
THE DISABLING CONDITION(S) LISTED ABOVE AND I HAVE TREATED	OTHE PATIENT WITHIN MY SCOPE OF PRACTICE.														
NURSE PRACTITIONER															
I CERTIFY UNDER PENALTY OF PERJURY THAT THE PATIENT IS UNA	ABLE TO PERFORM HIS/HER REGULAR OR CUSTOMARY WORK BECAUSE OF DITHE PATIENT WITHIN MY SCOPE OF PRACTICE. IF FOR A CONDITION OTHER														
THAN A NORMAL PREGNANCY OR DELIVERY, I CERTIFY THAT I HAV PHYSICIAN OR SURGEON.	E PERFORMED A PHYSICAL EXAMINATION AND HAVE COLLABORATED WITH A														
	NCAL OFFICER OF A US OCCUPRING METALS ASSESSED.														
REGISTRAR OF A COUNTY HOSPITAL IN CALIFORNIA OR MED I CERTIFY UNDER PENALTY OF PERJURY THAT THE PATIENT IS LINA	BLE TO PERFORM HIS/HER REGULAR OR CUSTOMARY WORK BECAUSE OF THE														
DISABLING CONDITION(S) LISTED ABOVE AND THESE CONDITIONS	ARE SHOWN BY THE PATIENT'S HOSPITAL CHART.														
OTHER: TITLE OF PERSON IF NOT COVERED ABOVE: (MUST BE ABLE TO LEGALLY CERTIFY TO A DISABILITY)															
PHYSICIAN/PRACTITIONER'S ORIGINAL SIGNATURE - RUBBER STAMP	DATE SIGNED														
IS NOT ACCEPTABLE	DATE SIGNED AREA CODE/PHONE NUMBER														
	M M D D V V V V														

UNDER SECTIONS 2116 AND 2122 OF THE CALIFORNIA UNEMPLOYMENT INSURANCE CODE, IT IS A VIOLATION FOR ANY INDIVIDUAL WHO, WITH INTENT TO DEFRAUD, FALSELY CERTIFIES THE MEDICAL CONDITION OF ANY PERSON IN ORDER TO OBTAIN DISABILITY INSURANCE BENEFITS, WHETHER FOR THE MAKER OR FOR ANY OTHER PERSON, AND IS PUNISHABLE BY IMPRISONMENT AND/OR A FINE NOT EXCEEDING \$20,000. SECTION 1143 REQUIRES ADDITIONAL ADMINISTRATIVE PENALTIES.



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