BACTES™
a sharecare company

State Disability Release Form (EDD)

You or your insurance company has requested a disability form to be completed. Bactes has been contracted by Corona Temecula Orthopaedics 341 Magnolia Avenue Suite 101 Corona, Ca 92879 to process your forms. **A processing fee of $30.00 for each new state disability form and $15.00 for each supplemental/extension form is required.** This payment is the responsibility of the patient and needs to be paid in full before completion of your form**.**

NO CASH PAYMENTS are accepted. Credit card, Check, or Money order only.

Please make checks/money order payable to BACTES

ALL FORMS MUST BE RETURNED TO CORONA ORTHOPAEDIC'S OFFICE

Patient Information	
Patient Name:	DOB:
Address:	
Phone:	Email:
Doctor who is currently treating you:	
Where do you want the form to be sent to after completion? *PRINT LEGIBLY*	
Company name: **EDD**	
Receipt number:	
Disability information:	
Has the doctor released you back to work? ☐ Yes ☐ No	
Dates you were out of work: to	
Date released back to work:	
Work restrictions/comments:	

I authorize Corona-Temecula Orthopaedic Associates to release my Protected Health Information as indicated above. This authorization covers the release of medical records to supplement my disability claim. I understand that:

- My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization.
- I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
- If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
- I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.
- I can request a copy of this form after I sign and date it. ****EXPIRES 1 YEAR FROM DATE SIGNED****

Signature:	Date:

Any questions please call the Disability Desk at 951-735-6060

Please allow 7-10 business days for processing

CREDIT CARD FORM

_____

Credit Card Payment

_____ ***I authorize Bactes to charge my credit card for the amount stated below.***

(Please Initial)

_____ _____ _____ _____ (_____/_____)

Credit Card Number Expiration Date

Card Type (Circle one) VISA MASTERCARD AMEX OTHER:_____

$_____

Amount to Charge Account

X_____ _____

Signature of Cardholder

_____

Name on Credit Card (Please Print)

_____

Billing Address of Cardholder

_____

City, State, Zip Code

(Please do not write below this line, for Bactes Use Only)

_____

Field Request ID