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FAX COVER

Date:

12-8-2015

To:

803-734-5167

Fax No:

Mrs. N. Haley

From:

Tina L. Higgins

Number of pages, including cover:

2

Claimant Name: Tina Haggins
Claimant Number: 2157227546

Authorization for Release of Medical and Employment Information: I authorize any health care providers, physician, medical practitioner, psychologist, chiropractor, hospital, clinic, pharmacy benefit manager or other pharmaceutical firm, insurance or reinsuring companies, the Medical Information Bureau, Inc., consumer reporting agency, Social Security Administration, financial institution, or employer having information about the history, diagnosis, treatment and prognosis with respect to any physical or mental condition, prescription drug records, financial status, employment status, or other relevant information of mine to give all information (except psychiatric treatment notes) to CUMIS Insurance Society, Inc. and CMFG Life Insurance Company and their affiliates and subsidiaries ("Company") or its reinsurers to determine eligibility for benefits. Information obtained will be released only to reinsurers, the Medical Information Bureau, Inc., persons performing business duties as delegated or contracted for by the Company related to my claim and subsequent insurance-related functions, as permitted or required by law, or as I further authorize. Some of the health information noted above may be disclosed to persons or organizations that are not subject to federal health information privacy laws, resulting in the information no longer being protected under such laws. I agree this authorization is valid for the duration of the claim. I understand that: (1) I can revoke this authorization at any time by giving written request to the Company; (2) revocation of this authorization will not affect any prior action taken by the Company in reliance upon this authorization; (3) failure to sign, or revocation of this authorization may impair the Company's ability to evaluate claims and may be a basis for denying this claim for benefits; and (4) I may receive a copy of this authorization.

For Residents of Vermont Only: This authorization does not include the disclosure of information concerning previously administered tests for the HIV antibody, T-Cell Counts, AIDS or ARC.

For Residents of Maine Only: This authorization excludes disclosure of previously administered tests for the HIV antibody, however, does not limit the release of other information or notes related to an AIDS diagnosis.

Tina Y. Haggins
Insured Claimant's Signature, Legal Guardian or
Authorized Personal Representative of the Estate

Supplemental Physician Statement

TO BE COMPLETED BY THE ATTENDING HEALTH CARE PROVIDER.
PATIENT IS RESPONSIBLE FOR ANY CHARGES FOR COMPLETING FORMS.

Work Release

Has patient been released to return to work or resume normal activities?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No	Never Returning
If yes, dates released to:	<input type="checkbox"/> Regular Duty:	<input type="checkbox"/> Restricted:	Hours per week:
Note: If you have released the patient to return to regular duty on a full time basis, you do not need to respond to the remaining questions. Please sign and date this form and return to CUNA Mutual Group.			

Diagnosis and Treatment

Current Diagnosis and/or Concurrent Conditions (including ICD-9):	GAF (if applicable)	Symptoms/Findings:
Systematic lupus erythematosus	M32.9	Multiple lesions on legs
Current Treatment Plan:		Address lesions
refer to Surgeon - possible wound debridement		Is patient still under your care? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Antibiotics		If no, date released: / /
DR. Pack for lupus		
If still under your care, frequency of treatment:	Date of Last Visit:	Date of Next Visit:
<input type="checkbox"/> Weekly <input checked="" type="checkbox"/> Monthly <input type="checkbox"/> Other:	11/19/2015	12/31/15
If patient had surgery, list procedure(s) performed:	CPT Codes(s):	Date of Surgery:
Wound Culture 9/30/15 - Biopsy	M32.9	9/30/15
Has this patient been referred to any other providers? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide name(s) and phone number(s) of other provider(s):	
DR. Pack		

Extent of Disability

Please provide current restrictions and limitations (what your patient can not do):		Date restrictions in place through:
Patient unable to return to work		
What do you expect regarding this condition?	<input type="checkbox"/> Improvement <input type="checkbox"/> No Change <input type="checkbox"/> Deterioration	Unknown
Disability is supported through	<input type="checkbox"/> based on <input type="checkbox"/> Expected Recovery <input type="checkbox"/> Next Evaluation Date	

Physician Information

Physician Name:	Cynthia A. Wilberding, M.D.	Tax ID #:	58-2292456
Street:	216 E. Marion St	Phone:	(803) 475-3350
City:	Hershaw	Fax:	(803) 475-5360
State:	SC	Zip:	29067
Person to contact if additional information is needed:	Freda Waters	Contact person phone (if different from above):	() - ext. ()
Physician Signature:	[Signature]	Date:	11/24/15
Degree/Specialty:	MD/ Internal Medicine		

For the concern of us all:

I'm writing to ask for help with medicare claims and the concerns on Disability claims also. I have been stricken with Lupus and I have been out of work for four months so far. I have filed for medicare and put in for Disability; because the lupus has affected my legs and feet; I have been in and out of the hospital; I have been filing for all the help that I can; and everyone is saying to wait. I have tried to be in the market place for insurance my I have no income for that source; So I'm writing to you to see if you can help us as Lupus Patients get insurance on if you can help us with a program that can help with medical term. Please help us if you can.

12/7/15 Jim Hassius