CHECKLIST FOR ALL FORMS

Form Fees: Initial Form ($25), Follow-up Form ($10)

****Delay of benefits may occur if ALL fields are not filled out.***

PATIENT TO COMPLETE:

Patient's Name: _____ **Patient's DOB:** _____

Patient's Phone #: _____ **VOA Physician/APP:** _____

Is this form for *(check one)*:

☐ Patient

☐ Caregiver: (If checked, please provide caregiver's name): _____

Does the employee plan to *(check one)***:** ☐ Work intermittently (reduced schedule) ☐ Not Work

Date employee last worked: _____

Return Documents via *(check one)***: *NOTE: Department of Labor (WHD) Forms must be picked up.**

☐ Pick Up: *(Contact name/number)*: _____

☐ Fax: *(if fee is paid in advance)*: _____

I acknowledge that I have read and completed the above information, recognize the 10-business-day completion requirement, and am aware of the form cost. I also acknowledge that if all fields are not completed, this could delay the delivery of benefits.

Patient signature: _____ **Date:** _____

VOA STAFF TO COMPLETE:

****Delay of benefits may occur for the patient if you do not complete ALL fields.***

Patient MRN: _____ **Date of next appointment:** _____

Type of Form *(check one)***:** ☐ FMLA ☐ Disability ☐ Insurance ☐ Other_____
(specify form)

Form Fees *(check one)***:**

☐ Initial form ($25) ☐ Follow up form ($10) ☐ No Charge *(reason)*_____

Payment Options *(check one)*: ☐ Paid Today ☐ Pay at Pickup

VOA Staff Member Name *(Print)*: _____

Location of request:

☐ Brock ☐ Chesapeake ☐ Elizabeth City ☐ Hampton ☐ Harbour View
☐ Obici ☐ Port Warwick ☐ Princess Anne ☐ Williamsburg