

# Short-Term Disability Claim Evaluation

## Claimant Information

Full Name

Date of Birth

Employee ID

Department

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## Claim Details

Claim Date

Type of Disability

Diagnosis

Onset Date

Expected Return to Work Date

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## Medical Provider Information

Provider Name

Provider Contact

**Evaluation**

Supporting Documentation Reviewed

Summary of Case Evaluation

Findings

Recommendation

**Decision**

Decision Status

Evaluator Name

Evaluation Date