Form Completion Process FAQ

The FAQ will help guide you through your FMLA/Disability or accident claim.

What is Sharecare, and what exactly do they do?
Sharecare is a health information management company contracted with Virginia Cardiovascular Specialists to provide services, including the completion of Disability and FMLA form paperwork.

How do I submit my FMLA or Disability paperwork?
There are several ways to get information to Sharecare:

- Return the form to the practice where you are seen
- Fax form to 804-288-4494

Is there a fee to have my forms completed?
Yes, there is a pre-payment fee of $30 for the first form plus any applicable sales tax.

If I need another form completed to continue my disability claim, will I have to make another payment?
Yes, a pre-payment fee of $15 per form plus any applicable sales tax for each consecutive or subsequent FMLA or Disability form regarding the same qualifying condition and claim.

How can I pay for my forms?
There are various ways to pay for your form:

Pay Online:

- Suppose you have provided a valid email address on your authorization form. In that case, you will receive an email notification with a payment link that will direct you to pay on the Sharecare payment portal website.
- If you did not provide an email address on your authorization form or cannot locate the email notification, you could pay online at payonline.hds.sharecare.com. You will need your ***Request ID*** to make the payment.

Pay by Phone:

- Contact the Sharecare Forms Department at 866-273-4039. We like to make it as easy and convenient as possible for you. We accept all major credit cards. We do not accept HSA cards as a payment method.

What is a Request ID?
A Request ID is a unique ID specific to the individual patient and form being completed. Sharecare assigns the ID, and if you are unable to locate it, you can contact Sharecare for assistance at 866-273-4039.

Do I need to sign an authorization form even if I want the form sent back to me?
Yes, we would like all the patients to fill out a Request for Form Completion document when requesting a form to be completed. This document provides the team with information on where and how to send the form. Also, if a disability insurance company calls, we cannot give any information without consent, thus delaying your claim with your disability company. In addition, this document asks for the patient to identify the treating provider, injury/problem date, and last day worked, which will aid in completing your form.

I do not use email or know my Request ID number. How can I get status updates on the completion of my form?
You can contact the Sharecare Forms Department at 866-273-4039 for the status of your form, as well as the Request ID number associated with your form.

I need to update the information on my FMLA or Disability paperwork. What do I need to do?
We understand that FMLA forms, as well as disability determinations, may require an update of your medical information from your recent doctors' visit. You will need to re-submit the new paperwork to Virginia Cardiovascular Specialists for Sharecare to complete in such cases. There will be a fee of $15.00 required for any updates requested.

When will I receive my completed forms?
Please allow 48 hours for Sharecare to receive your form from the time you submit it to Virginia Cardiovascular Specialists. Once payment is received, it may take up to 5-7 business days to complete the forms. It is imperative to submit all information and make the pre-payment as soon as possible; failure to do so will delay the process.

I submitted my paperwork but no longer need it to be completed. How can I cancel it?
You can contact the Sharecare Forms Department at 866-273-4039 for assistance.

I still have questions?
Please reach out to our team at Sharecare, and we are happy to discuss any questions you might have. Contact us at 866-273-4039.

Date: __ __/__ __ /__ __ __ __

Request for Form Completion

Phone: 804-288-4827 | Fax: 804-288-4494

Pre- Payment is Required. Please allow 5-7 business days for completion of form(s).

A fee per form is due prior to completion of the form(s).
The fee schedule is as follows:
$30 for initial form, $15.00 for updates for same qualifying condition, plus any applicable sales tax.
You will be contacted by Sharecare with payment options after you return this paperwork.

What is your relation to the patient? ☐ I am the Patient ☐ I am a Family Member-Name:_____

Patient Name:_____
(Last) (First) (Middle / Maiden)

Address:_____

City:_____ State:_____ Zip:_____

Social Security #: ___ ___ ___-___ ___-___ ___ ___ ___ Date of Birth: ___ ___ / ___ ___ / ___ ___ __ ___

Telephone #: ___ ___ ___ / ___ ___ ___ / ___ ___ ___ ___ Cell/Work #: ___ ___ ___ / ___ ___ ___ / ___ ___ ___ ___

Physician:_____ **Body Part:**_____

Date Injury/Problem Began:_____ **Last Day Worked:**_____

For Patients requesting leave for themselves, what is the date(s) that you anticipate returning to work:_____

Please check a reason: ☐ Continuous Leave ☐ Surgery and Post-Op Treatment ☐ Intermittent Leave

For Family Members requesting leave, what date(s) do you anticipate being out of work:_____

I authorize Virginia Cardiovascular Specialists to release the completed form(s) and/or the use and disclosure of my individually identifiable health information to:

Name/Organization: _____

Address: _____

City:_____ State:_____ Zip:_____

Telephone #: ___ ___ ___ / ___ ___ ___ / ___ ___ ___ ___ Fax #: ___ ___ ___ / ___ ___ ___ / ___ ___ ___ ___

Email Address: _____

Please check your preferred method of release:

☐ Email the form to the above email address
☐ Mail the form to the patient's address
☐ Mail the form to the Name/Organization above
☐ Fax the form to number provided above

I understand that: I may refuse to sign this authorization and that it is strictly voluntary. 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. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____ **If I do not specify expiration this authorization will expire in 90 days.** 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. I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. * _____(Please Initial)

Signature:_____ Date:_____
(Patient or Authorized Representative – Relationship: ☐ Spouse ☐ Parent ☐ Other:_____)

Revised: 7/2021