MANITOBA BLUE CROSS®

CLHIA ACCAP

APPLICATION FOR BENEFITS
Attending Physician's Statement - Long Term Disability Claim

The patient is responsible for any fees related to the completion of this form.
Submit directly to Manitoba Blue Cross, Case Management Services.
Email LDinfo@mb.bluecross.ca, Fax 204.788.5591 or Mail PO Box 1046 Stn Main, Winnipeg MB R3C 2X7

PART 1 - EMPLOYEE (MEMBER) TO COMPLETE

Employee Name (Last, First, Middle Initial)	Phone Number (include area code)

Address (Street, City, Province, Postal Code)

Employer's Name	Plan/Policy ID	Certificate Number

Last Date Worked (yyyy-mm-dd)	**Date Returned to Work or Expected Return to Work Date** (yyyy-mm-dd)

Please list your present medications

Name of Medication	Dosage (mg)	How Often?

Please provide your

Height _____

Weight _____

Dominant Hand

Left ☐ Right ☐

I hereby authorize the release of personal information and personal health information in my file to Manitoba Blue Cross and/or its authorized agents for the purpose of assessing my disability claim and administering the benefits plan. This personal information and personal health information includes, but is not limited to, copies of all consultation reports, clinical notes, test results, and hospital records. Medical and health information excludes genetic test results. I understand that I can revoke this consent at any time but that without it my claim cannot be assessed. I understand that I am responsible for any fees related to the completion of this form.

_____ _____

Employee (Member) Signature Date of Consent (yyyy-mm-dd)

PART 2 - PHYSICIAN TO COMPLETE

I am the: Family Physician ☐ Consulting Specialist ☐ Other ☐ (please specify) _____

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

DIAGNOSIS

Primary _____

_____

_____

_____

Secondary and/or Complications _____

_____

_____

_____

If Childbirth - Delivery Date (yyyy-mm-dd) _____ Expected ☐ Actual ☐ Delivery Method - Vaginal ☐ C-Section ☐

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Is this condition due to

Occupational illness/injury Yes ☐ No ☐ Auto accident Yes ☐ No ☐

If yes, date of event (yyyy-mm-dd) _____ If yes, date or event (yyyy-mm-dd) _____

Have you completed any other disability claim forms recently for this patient? Yes ☐ No ☐

If yes, please indicate requestor (other insurance company, CPP, QPP, Workers Compensation Board, etc.) _____

_____

Date of first visit to you pertaining to this condition	**First Date of work absence due to condition**
(yyyy-mm-dd) _____	(yyyy-mm-dd) _____

Treatment

e.g. special programs, therapies, medication, and dosage

_____

_____

_____

_____

_____

_____

Frequency of visits Weekly ☐ Monthly ☐ Other ☐ _____

Date of last visit (yyyy-mm-dd) _____ Treatment Provider _____

Is the patient following the recommended treatment program? Yes ☐ No ☐

Please elaborate _____

Response to Treatment

Please describe the response to treatment to date Complete ☐ Partial ☐ None ☐ Too soon to tell ☐

Are there any plans to change or augment the current treatment program? Yes ☐ No ☐

If so, please explain _____

_____

_____

_____

Hospitalization

Is/was the patient hospitalized? ☐ Yes ☐ No Is future hospitalization planned? ☐ Yes ☐ No

Date of admittance (yyyy-mm-dd)	Date of discharge (yyyy-mm-dd)	Institution name

If surgery was/will be performed, please provide date(s) and description of surgery

Date (yyyy-mm-dd)	Description

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Investigations

PLEASE ATTACH COPIES OF ALL RELEVANT
- test results/investigations - do not provide genetic test results
  If test results are not attached, we will interpret this as tests were not performed
- consultation reports

Are tests/investigations pending? ☐ Yes ☐ No (if Yes, please indicate below)

Date (yyyy-mm-dd)	Description

If consultation report is not attached, will the patient be seen by a specialist(s) for this condition in the future?

Yes ☐ No ☐ (if Yes, please indicate below)

Name of Specialist	Specialty	Date (yyyy-mm-dd)

Clinical Findings and Observations

Please describe the patient's symptoms including history, severity, and frequency

How have the patient's symptoms evolved to date? Improved ☐ No Change ☐ Retrogressed ☐

Please explain _____

Clinical Findings and Observations

Based on your clinical findings and observations, please describe the patient's current cognitive and/or physical restrictions and limitations

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Has any licence held by the patient been restricted or revoked as a result of this condition Yes ☐ No ☐

If yes, as of when (yyyy-mm-dd) _____ Type of licence _____

for how long _____

Do you have concerns about the patient's ability to manage own affairs? Yes ☐ No ☐

Are there other non-medical factors that may impact the patient's expected recovery period and return-to-work goals? Yes ☐ No ☐

Please elaborate _____

Prognosis

Please provide the patient's prognosis for improvement and/or recovery.

Please elaborate _____

Return-to-Work

What return-to-work goals have been discussed with the patient?

Please elaborate _____

Notice to Physician

The information in this statement will be kept in a life, health or disability benefit file with the insurer or plan administrator, and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information you consent to such unedited release of any information contained herein.

Physician's Name (please print)	Certified Specialty	Physician's Stamp
Address (Street, City, Province, Postal Code)		
Telephone Number (include area code)	Fax Number (include area code)	
Signature	**Date Signed (yyyy-mm-dd)**	