MANITOBA BLUE CROSS®

CLHIA ACCAP

APPLICATION FOR BENEFITS
Attending Physician's Statement - Short 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

Height	Weight	Date of Birth (yyyy-mm-dd)

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

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 (or Nurse Practitioner where applicable)

STOP

- **If your patient has returned to work, or is expected to return to work within 4 weeks of the Last Date Worked, complete Page 1 only and sign the end of the form**
- **For absences expected to be greater than 4 weeks, please complete Pages 1 and 2 in full.**

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

Primary Diagnosis _____

Secondary and/or Complications _____

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

Occupational illness/injury Yes ☐ No ☐	**Auto accident** Yes ☐ No ☐
If yes, date of event (yyyy-mm-dd) _____	If yes, date of event (yyyy-mm-dd) _____
Date of first visit to you pertaining to this condition (yyyy-mm-dd) _____	**First date of work absence due to condition** (yyyy-mm-dd) _____

Hospitalization Is/was patient hospitalized? ☐ or had day surgery? ☐

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

Surgery If surgery was/will be performed, please provide date and description of surgery

Date (yyyy-mm-dd) _____ Description _____

Treatment (medications, dosage, therapies, other)

Prognosis (provide the prognosis for recovery)

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Continuation of Attending Physician's Statement for ABSENCES THAT MAY BE GREATER THAN 4 WEEKS

Has the patient been treated for this same or similar condition in the past? Yes ☐ No ☐

If yes, date (yyyy-mm-dd) _____ Treatment Provider _____

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

Frequency of Visits Weekly ☐ Monthly ☐ Other ☐ _____

➔ **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**

If consultation report is not attached, please indicate if your patient has or will be seen by a specialist for this condition.

Name of Specialist _____ **Specialty** _____ **Date** _____

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

Please list any complications and additional conditions impacting your patient's level of function or the expected recovery period

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

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

Prognosis (provide the prognosis for improvement/recovery if not completed on Page 1)

Notice to Physician (or Nurse Practitioner)

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)	