MANITOBA BLUE CROSS®

Case Management Services

PROOF OF DEATH PHYSICIAN'S STATEMENT

Submit directly to Manitoba Blue Cross, Case Management Services.
Fax: 204.788.5591 Email: LDinfo@mb.bluecross.ca Mail: PO Box 1046 Stn Main, Winnipeg MB R3C 2X7

PHYSICIAN'S STATEMENT

Name of Deceased	Residence at Death

Date of Birth (yyyy-mm-dd)	Date of Death (yyyy-mm-dd)	Place of Death (if hospital, give name)

Cause of Death *an explanation is required for (1), (2) and (3)

1) Disease or condition directly leading to death (does not mean the mode of death but the disease, injury or complication which caused death)

Interval between onset and death

2) Antecedent cause (morbid conditions, if any, giving rise to the above cause, stating the underlying cause)

Interval between onset and death

3) Other significant conditions (contributing to the death but not related to the disease or condition causing death)

Interval between onset and death

Was the deceased a smoker at time of death? Yes ☐ No ☐ Unknown ☐ If yes, how long did deceased smoke?

Date of first attendance in last illness (yyyy-mm-dd)	Date of last attendance in last illness (yyyy-mm-dd)

If death is due to accident, homicide or suicide, specify which and describe

Was inquest held? Yes ☐ No ☐

Was autopsy performed? Yes ☐ No ☐ If yes, provide the coroner's name and findings

Have you treated the deceased during the last 3 years? Yes ☐ No ☐

To your knowledge, did the deceased receive treatment during the last 3 years from any other physician or in any Hospital or Facility?
Yes ☐ No ☐ Unknown ☐ If yes, please complete below

Physician/Hospital Name	Address	Condition	Dates of Treatment (yyyy-mm-dd)

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)	