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. Fax 204.788.5591 Mail PO Box 1046 Stn Main, Winnipeg MB R3C 2X7

PART 1 – EMPLOYEE (MEMBER) TO COMPLETE

Employee (Member) Name (Last, First, Middle Initial) ☐ Male ☐ Female	Home Phone Number (+ Area Code)	Cell Phone Number (+ Area Code)

Address (Street, City, Province, Postal Code)

Employer's Name	Policy ID (5 digit number)	Member Certificate Number	Date of Birth (yyyy-mm-dd)

Date Last 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?
1.		
2.		
3.		
4.		
5.		

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. 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 - Expected or Actual Delivery Date (yyyy-mm-dd)_____ 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 of 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

(yyyy-mm-dd)_____

First date of work absence due to condition

(yyyy-mm-dd)_____

Treatment

e.g. Special Programs, Therapies, Medications (if not noted by patient in **Section 1)**

_____

_____

_____

_____

_____

Frequency of Visits Weekly ☐ Monthly ☐ Other ☐ (describe)_____

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

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

If yes, date (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
1.			
2.			
3.			

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

	Date (yyyy-mm-dd)	Description
1.		
2.		

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Investigations

Please attach copies of all relevant
- **test results/investigations (If test results are not attached, we will interpret this as tests were not performed)**
- **consultation reports**

Are tests/investigations pending? Yes ☐ No ☐

	Date (yyyy-mm-dd)	Description
1.		
2.		
3.		
4.		

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

Yes ☐ No ☐

	Name of Specialist	Specialty	Date (yyyy-mm-dd)
1.			
2.			
3.			
4.			

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 ☐

Restrictions and Limitations

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

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_____

Do you have concerns about the patient's ability to manage his/her 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.

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 benefits 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 I 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 (+ area code)	Fax Number (+ area code)	
Signature	Date Signed (yyyy-mm-dd)	