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. 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	Plan/Policy ID Number	Member 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. 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 - Expected or Actual Delivery Date (yyyy-mm-dd)_____ Vaginal ☐ C-Section ☐

Occupational Illness/injury Yes ☐ No ☐ If yes, date of event (yyyy-mm-dd)_____	Auto accident Yes ☐ No ☐ 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 (drug, dosage, physiotherapy, 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 (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 of Visit _____

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 his/her own affairs? Yes ☐ No ☐

Prognosis (provide the prognosis for recovery if not completed on page 1)

Notice to Physician (or Nurse Practitioner where applicable)

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)	