MANITOBA BLUE CROSS®

Case Management Services

ATTENDING PHYSICIAN'S STATEMENT
APPLICATION FOR CRITICAL CONDITION BENEFIT

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

PART 1 - Patient Authorization

Patient's Name		Date of Birth (yyyy-mm-dd)
Policyholder (Employer Name)	Plan/Policy ID	Certificate Number

I hereby authorize the release of personal information and personal health information in my file to Manitoba Blue Cross, Blue Cross Life Insurance Company of Canada (collectively referred to as "Blue Cross") and/or its authorized agents for the purpose of assessing my 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.

Patient's Signature _____ Date (yyyy-mm-dd) _____

PART 2 - Attending Physician's Statement

Primary Diagnosis _____

Secondary Diagnosis _____

Additional conditions or complications _____

Canadian Cardiovascular Society Classification (if applicable). Attach results of stress tests, angiogram, etc.

Class 1 - No limitation ☐ Class 2 - Slight limitation ☐ Class 3 - Marked limitations ☐ Class 4 - Complete Limitations ☐

Prognosis _____

PLEASE ATTACH COPIES OF ALL RELEVANT

➔ Consultation reports, operative reports, hospital admission and discharge reports, test results/investigations including pathology reports.
Do not provide genetic test results. If test results are not attached, we will interpret this as tests were not performed.

Date symptoms first appeared/condition onset (yyyy-mm-dd) _____

Has patient ever had same or similar condition? Yes ☐ No ☐ If yes, give dates and details _____

Date patient first received medical treatment, diagnostic measures, medication or consultation for this condition (yyyy-mm-dd) _____

Summarize patient's medical history and treatment _____

Are you aware of other treating physician(s) due to this present condition? Yes ☐ No ☐ If yes, please give name(s) and address(es)

Indicate how each of the activities of daily living are affected by this condition

eating _____

dressing _____

bathing _____

ambulation _____

toileting _____

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

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)	