ALBERTA BLUE CROSS®

CLHIA ACCAP

ATTENDING PHYSICIAN STATEMENT
SHORT TERM DISABILITY CLAIM

10009 108 Street NW, Edmonton, Alberta T5J 3C5
Telephone: 587-756-8631 or 1-800-763-6206
Fax: 780-441-2605 Toll-free fax: 1-855-660-2605
ab.bluecross.ca

Submit directly to Alberta Blue Cross, Life & Disability Services. See contact information above.
It is the responsibility of the plan member to submit the Employee Statement and Attending Physician Statement.
The plan member is responsible for submitting this completed form and accepting any charges for its completion.

1. This section to be completed by employee (plan member)

Last name	First name	Middle initial	Birth date (YYYY-MM-DD)	Gender ☐ M ☐ F

Mailing address	City/town	Province	Postal code

Home telephone	Cell phone	Email address	Dominant hand ☐ Left ☐ Right	Height	Weight

Employer's name	Group/policy number	Section	ID number	**Date last worked (YYYY-MM-DD)**	**Date returned to work/ expected return date (YYYY-MM-DD)**

I hereby authorize the release of health information in my file by the health-care provider listed on this form to Alberta Blue Cross, Blue Cross Life Insurance Company of Canada* and/or its authorized agents for the purposes of determining eligibility for coverage, assessment, paying claims, audit, investigation, underwriting, administration and claims management. This health information includes, but is not limited to, copies of all consultation reports, my medical history, 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I can revoke this consent at any time in writing; however, if consent is withheld or revoked, coverage may be denied or rescinded.

I understand why I have been asked to disclose this information, and am aware of the risks and benefits of consenting, or refusing to consent, to the disclosure.

I agree that this consent shall be effective on the date noted below and shall be valid for the duration of the time my benefit coverage is in force.

I agree that a copy or electronic version of this authorization shall be as valid as the original.

For a copy of our privacy policies, or questions about our personal information policies and practices, please refer to **ab.bluecross.ca** or email our privacy compliance officer at **privacy@ab.bluecross.ca**.

Signature of employee (plan member)	Date of consent (YYYY-MM-DD)

2. Attending physician statement TO BE COMPLETED BY THE DOCTOR

STOP

- **If your patient has returned to work or is expected to return to work within four weeks of the last date worked, complete sections 2 and 4.**
- **For absences expected to be greater than four weeks, please complete sections 2, 3 and 4.**

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

1. Diagnosis

Primary diagnosis

Secondary diagnosis or complications

If childbirth ☐ vaginal ☐ C-section Expected or actual delivery date (YYYY-MM-DD)	Occupational illness/injury ☐ Yes ☐ No If yes, date of the event (YYYY-MM-DD)	Auto accident ☐ Yes ☐ No If yes, date of the 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)

2. Hospitalization

Is/was the patient hospitalized ☐ or had day surgery ☐

Date of admittance (YYYY-MM-DD)	Date of discharge (YYYY-MM-DD)	Institution name
1.		
2.		

If surgery was performed, please provide the date and description of surgery

Date (YYYY-MM-DD)	Description
1.	
2.	

3. Treatment

Drug, dosage, physiotherapy, other

4. Prognosis

Please provide the prognosis for recovery

3. Continuation of Attending Physician's Statement for absences that may be greater than four weeks

Has the employee 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 and investigations (if test results are not attached, we will interpret this as tests were not performed) and**
- **consultation reports.**

Do not provide genetic test results.

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 (YYYY-MM-DD)

Based on your clinical findings and observations, please describe the patient's current cognitive and 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 Please provide the prognosis for recovery (if not completed in Section 2)

4. Notice to physician

The information in this statement will be kept in a life, health or disability benefits file with the insurer 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.

Attending physician (please print)	Certified specialty		Physician's stamp
Mailing address	Province	Postal code	
Phone number	Fax number		
Signature	Date signed (YYYY-MM-DD)		

*Blue Cross Life Insurance Company of Canada underwrites all life and income replacement benefits.

ABC 55086/31043 Physician's Statement General Short Term Disability 2017/12