ALBERTA BLUE CROSS®

CLHIA ACCAP

ATTENDING PHYSICIAN STATEMENT
LONG 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	Height	Weight
			☐ Left ☐ Right		

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)**

Please list your present medications

Name of medication	Dosage (mg)	How often?
1.		
2.		
3.		
4.		
5.		

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I can revoke this consent at any time in writing; however, if consent is withheld or revoked coverage may be denied or rescinded.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

I am the ☐ Attending physician ☐ Consulting specialist ☐ Other (please specify) _____

PLEASE COMPLETE TO THE BEST OF YOUR KNOWLEDGE

1.	**Diagnosis**
	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 the event (YYYY-MM-DD)

Auto accident ☐ Yes ☐ No
If yes, date of the 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)

2. Treatment

For example, 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

3. 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

Please elaborate

4. 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.		

5. Investigation

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)**
- **consultation reports**

Do not provide genetic test results.

Are tests/investigations pending? ☐ Yes ☐ No

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

If consultation report is not attached, will the patient be seen by specialists for this condition in the future? ☐ Yes ☐ No

	Name of specialist	Specialty	Date (YYYY-MM-DD)
1.			
2.			

6. 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

7. 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 license 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 license
Do you have concerns about the patient's ability to manage his or 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

8. Prognosis

Please provide the patient's prognosis for improvement and recovery

9. Return-to-work

What return-to-work goals have been discussed with the patient? Please elaborate

3. 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.

Name of attending physician	Physician's 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.

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