SASKATCHEWAN BLUE CROSS®
516 2nd Avenue North, PO Box 4030
Saskatoon, SK S7K 3T2

ATTENDING PHYSICIAN'S STATEMENT
CRITICAL ILLNESS BENEFIT

PATIENT AUTHORIZATION

Patient's Name | Date of Birth (YYYY/MM/DD)

I authorize the release of personal information and personal health information in my file by the healthcare provider listed on this form to Saskatchewan Blue Cross, Blue Cross Life Insurance Company of Canada and/or its authorized agents for the purposes of determining eligibility for coverage, underwriting, adjudicating and paying claims, administering products and services, audit and investigation. This personal information and personal health information includes, but it 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 my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time in writing; however, if consent is withheld or revoked, coverage may be denied or rescinded. I understand why my personal information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding the privacy policies of Blue Cross and/or the collection, use or disclosure of my personal information, I can visit www.sk.bluecross.ca or call 1.800.667.6853."

Patient's Signature | Date (YYYY/MM/DD)

ATTENDING PHYSICIAN'S STATEMENT

Diagnosis:

Date symptoms appeared: (YYYY/MM/DD) _____

Date patient first received medical treatment, diagnostic measures, medication, or consultation for this condition: _____

Has patient ever had same or similar condition? ☐ Yes ☐ No

If yes, give dates (YYYY/MM/DD) and details:

Date of Hospital Treatment (if applicable):

Outpatient : _____ (YYYY/MM/DD)

Inpatient Admission: _____ (YYYY/MM/DD)

Discharge: _____ (YYYY/MM/DD)

Name of Hospital | Address of Hospital

Surgical treatment, if any (details, dates):

Are you aware of other physician's who treated this patient due to this present condition? ☐ Yes ☐ No

If yes, please outline in the chart below:

	Medical Practitioner Name	Address	Telephone Number	Fax Number
Family Doctor				
Specialist				
Specialist				
Specialist				

Please enclose copies of all relevant test results (including all lab work, stress tests, angiogram, ECG, MRI, etc.), investigative tests, pathology reports, hospital records and consultation reports or any other relevant clinical findings.

COMPLETE FORM ON NEXT PAGE.

Please indicate how activities of daily living are affected by this condition:

Eating	
Dressing	
Bathing	
Ambulation	
Toileting	

Please outline your prognosis for this patient.

Is there any other information you wish to provide to assist us in the review of your patient's claim?

Remarks:

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 Address

Speciality Telephone Number Fax Number

Signature Date (YYYY/MM/DD)