BFL Canada Risk and Insurance Inc.

2001 McGill College Suite 2200,
Montréal, Québec, H3A 1G1

Tél: (514) 843-3632 / 1-800-465-2842
Fax: (514) 843-8280 / (514) 843-3842
Email: claims@bflcanada.ca

ATTENDING PHYSICIAN'S STATEMENT - HEALTH INSURANCE CLAIM

ACCIDENT

PATIENT'S NAME AND ADDRESS	AGE

1 A	Diagnosis and Concurrent Conditions (If fracture or dislocation, describe nature and location)	
B	Is condition due to injury or sickness arising out of patient's employment? If "Yes" explain	Yes ☐ No ☐
2 A	When did symptoms first appear or accident happen?	Date ________ Year: ____
B	When did patient first consult you for this condition?	Date ________ Year: ____
C	Has patient ever had same Or similar condition? If "Yes" state when and describe	Yes ☐ No ☐
3 A	Nature of surgical or obstetrical procedure, If any (describe fully)	Date performed ________ Year: ____
B	Charge to patient for this procedure including post-operative care	$ ____
C	If performed in hospital, give name of hospital	________ Inpatient ☐ Outpatient ☐
4	Give dates of other medical (non-surgical) treatment, if any	Office ________ Home ________ Hospital ________ Nursing Home ________
5	What other services, if any, did you provide patient? (Itemize, giving dates and fees)	
6	Where registered private duty nurse (R.N.) Services necessary?	
7	Is patient still under your care for this condition? If "No" give date your services terminated	Yes ☐ No ☐ Date ________ Year: ____
8 A	How long was or will patient be continuously totally disabled? (Unable to work?)	From ____ Year:____ Thru ____ Year:____
B	How long was or will patient be partially disabled?	From ____ Year:____ Thru ____ Year:____
C	Was house confinement necessary? If "Yes" give dates	Yes ☐ No ☐ From ____ Year:____ Thru ____ Year:____
9	To your knowledge, does patient have other health insurance or Health plan coverages? If "Yes" identify	Yes ☐ No ☐

REMARKS

DATE	SIGNATURE (ATTENDING PHYSICIAN)	DEGREE	TELEPHONE
STREET ADDRESS	**CITY OR TOWN**	**PROVINCE**	**POSTAL CODE**