gpm group benefits

250-2 Place Laval, Laval, QC H7N 5N6
T 450.667.7737 | disability@gpm.ca | gpm.ca

SHORT-TERM DISABILITY CLAIM
Attending Physician Form

Group No. ______ **GPM User ID** ______

INSTRUCTIONS

1. **FILL-IN THE FORM.** Please note that the cost incurred to complete this form is the patient's responsibility.
2. **PATIENT AND PHYSICIAN SIGNATURES ARE REQUIRED.**
3. **RETURN ADDRESS** Please send this form to your patient or send it by fax to 450.667.7739 in complete confidentiality. It is not necessary to send us the original documents. Please keep the original for your records.

PARTICIPANT INFORMATION AND AUTHORIZATION - To be completed by patient

Participant's Family Name(s) | Participant's Given Name(s) | Date of Birth (d/m/y)

Address (Street No. and Street Name, Apartment)

City and Province | Postal Code

Phone No. | Participant's Email Address

DECLARATION AND AUTHORIZATION

By submitting your claim, you confirm that the information provided is accurate, precise and true. Any false information may result in the rejection of your claim. You authorize GPM and its representatives to: (i) Investigate all providers of goods or services and obtain all information relating to the goods sold and services provided; (ii) Collect information regarding the reimbursement request or the claim; (iii) Obtain, use and disclose personal information concerning you or the persons referred to in your claim, necessary for its due diligence to determine its veracity. Note that we will share information relating to a false declaration or fraudulent claim to the competent authorities as well as to the Policyholder. You also agree that the person to whom the request for information is addressed to, answers the questions submitted for the verification of your claim and our inquiry. I authorize GPM to use my social insurance number. I authorize any person or entity that has relevant personal information about me, including my employer, health professionals, my doctor, medical institutions, insurers, and persons performing services on behalf of GPM to disclose the information necessary to the activities of pricing, management and payment of claims. I authorize GPM to convey to my long- term disability insurance company any information about my absence to ensure the transition of my application to my long-term disability plan. I agree that I am responsible to keep the original documents relating to my claim for short-term disability. I agree that a photocopy of this authorization is as valid as the original.

PARTICIPANT'S SIGNATURE | Date (d/m/yyyy)

PHYSICIAN'S STATEMENT

Primary Diagnosis: | Secondary Diagnosis:

Occupational Illness or Injury

Is the patient's condition due to the performance of his duties?

○ No ○ Yes

Start Dates of Current Disability

Date of the first visit during current period of disability (d/m/yyyy) | Date of first day of absence from work due to condition (d/m/yyyy)

Hospitalization

Has your patient been hospitalized?

○ No ○ Yes » Please indicate:

Date admitted (d/m/yyyy) | Date discharged (d/m/yyyy)

Was surgery performed?

○ No ○ Yes » Please indicate:

Description | Type of anaesthetic

Treatment

Medication, dosage, therapy, other:

To your knowledge, is the patient following the recommended treatment plan? ○ No ○ Yes **COMMENTS**

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Following the declaration of the attending physician - IF THE ABSENCE IS LIKELY TO CONTINUE BEYOND 4 WEEKS

History

Has the patient been treated for this condition in the past?

No Yes » Please indicate: DATE (d/m/y) ______ DATE (d/m/y) ______ DATE (d/m/y) ______

Symptoms

Please describe current symptoms, severity and frequency:

Investigations

PLEASE ATTACH COPIES OF ALL RELEVANT.

- **Test results**
- **Consultation reports from specialists**

* If no results are given, we will assume that no examinations were made.

Are tests / investigations pending?

No Yes » Please indicate:

Specify the date of expected results: DATE (d/m/y) ______

Restrictions and Limitations

Based on your findings and clinical observation, please describe your patient's current cognitive and/or physical restrictions and limitations:

Complications and Other Conditions

Please list any complications and additional condition that may have an impact on your patient's level of function for the expected recovery period:

Expected Date of Return to Work / Prognosis

Attending Physician's Acknowledgement (Please print)

Physician's Family Name(s)

Physician's Given Name(s)

Certified Speciality

Address (Civic No., Street Name, City, Province, Postal Code)

Phone No.

Fax No.

PHYSICIAN'S SIGNATURE

Date (d/m/yyyy)

Physician's stamp