DMI DISABILITY MANAGEMENT INSTITUTE INC.

CLAIM FOR MEDICAL ABSENCE BENEFITS

Advice2Pay

Employer Statement

INSTRUCTIONS

Employer

Complete the Employer's Statement and fax to DMI at **604-542-3850 / 1-866-963-9994**.
The Employee Statement is to be completed by the employee who is then to fax the form directly to DMI
The Attending Physicians statement is to be completed by the employees physician who is then to fax the form directly to DMI
Should you have any questions regarding the completion of this form please call DMI at **604-542-3649 / 1-866-963-9995**

Employers Statement

Employer's Company Name			Employer Contact (Name) Employer Contact Phone Number
Employee Surname	First Name	Initial	Employee Job Title
Date last worked (dd/mm/yy) ______/______/______	Date returned to work *(dd/mm/yy)* ______/______/______		Brief Summary of Employees Typical Duties

Indicate Typical Schedule	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Is absence due to a work related injury or illness? ❑ YES ❑ NO	Has a claim been filed with WCB, WSBC or WSIB ❑ YES ❑ NO	If YES, Date claim filed (dd/mm/yy) ______/______/______	If WCB Claim filed, What is status of claim?

Please include any other information which may help the Disability Management Institute assess this claim

This certifies that according to our records, the employee was covered under our plan when this disability commenced.

Authorized official's signature	Title	Date Signed

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Employee Statement

INSTRUCTIONS	
Employee	Complete Employee's Statement and fax to DMI at **604-542-3850 / 1-866-963-9994**. The Attending Physicians Statement is to be completed by your physician. Take the Attending Physicians Statement to your doctor and once completed, have it faxed directly to DMI **a 604-542-3850 / 1-866-963-9994**

Employee's Statement

First Name	Last Name	Occupation	❑ Male ❑ Female

Street Address	Apt No.	City	Province	Postal Code

Telephone Number ( )	Date of Birth (dd/mm/yy) ______/______/______

Date first unable to work because of disability (dd/mm/yy)	Date of return to work or expected return to work (dd/mm/yy)

In what way are you / were you impaired as a result of your injury/illness? Please describe

Is your inability to work due to a MVA? ❑YES ❑NO	If yes, Date of Accident (dd/mm/yy) ______/______/ ______

Were you injured while performing work related duties? ❑ YES ❑ NO	Has/ will a claim be filed for Worker's Compensation? ❑ YES ❑ NO

I authorize the release to the Disability Management Institute (DMI) to receive complete written reports covering diagnosis, treatment, prognosis and all other related medical information that is required as a result of my claim for Medical Absence benefits. I authorize the Disability Management Institute to release relevant medical reports to the relevant medical professionals, medical related facilities, insurers and the Worker's Compensation Board. I authorize the Disability Management Institute and my Employer to exchange necessary information relative to my ability to return to work. A photocopy of this authorization will be as valid as the original.

Employee's Signature ____ Date ____________________

CLAIM FOR MEDICAL ABSENCE BENEFITS
Attending Physicians Statement

DMI Disability Management Institute Inc. — Advice2Pay

INSTRUCTIONS

Employee	Take this form to your Doctor for completion. Any charges are your responsibility. Once completed, sign and date the authorization at the bottom and fax (or have your physician fax) the completed form directly to DMI **at 604-542-3850 or toll free 1-866-963-9994**
Physician	Complete this form and return it to the employee or fax directly to DMI at **604-542-3850 or toll free 1-866-963-9994** Any charges for these services are the responsibility of the Employee

ATTENDING PHYSICIAN'S STATEMENT

Full Name of Patient	Date of Birth *(dd/mm/yy)*	Patient Home Phone ( ) -	Employer

Primary Diagnosis of present condition (for Psychiatric diagnosis include DSMV-IV GAF):

Axis I:
Axis II:
Axis III:
Axis IV:
Axis V (GAF):

Additional Information (secondary diagnosis, conditions or complications which might affect duration of absence from work)

When did the symptoms first appear/date of accident (dd/mm/yr) ______/______/______	Is this illness/injury the result of a work injury/exposure ☐ Yes ☐ No ☐ Unknown
If admitted to hospital what was the date of admission (dd/mm/yr) ______/______/______	If admitted to hospital what is/was the discharge date (dd/mm/yr) ______/______/______
If pregnant what is patients due date/removal of bed rest (dd/mm/yr) ______/______/______	What was the date the patient was unable to work due to the described medical condition (dd/mm/yr) ______/______/______
What is date the patient should be able to return to work (dd/mm/yr) ______/______/______	If no specific return date, what is the estimated number of weeks the patient will need to be off work ____________

Treatment *(*Nature of treatment including date and type of surgery, treatment or post operative treatment including medication dosage and frequency)

Referral If you have referred patient to a specialist, provide name(s) of physician(s), specialty and date:
- provide copy of consultation report(s)

Tests (Specify tests completed or scheduled - provide copies of all reports/test results)

Supervision Have you been involved in the patients care since onset of presenting condition ☐ Yes ☐ No Comments

Medical follow-up Is further medical follow-up anticipated prior to the patients return to work ☐ Yes ☐ No If yes, please provide follow-up date (dd/mm/yr) ______/______/______

What are the current physical and/or cognitive limitations (note activity, and/or weight, frequency limitations)

Is patient fit for trial return to work on part-time or modified basis? ☐ Yes ☐ No If "Yes", indicate date (dd/mm/yr) ______/______/______ Details:

Remarks (Please provide any comments and further details which you feel would be helpful in the assessment of this claim)

Name of Attending Physician *(print)*	Specialty	Telephone Number ( ) -	Fax number ( ) -

Address *(number, street, city, province, postal code)*

Physician's Stamp Here

Physician's Signature	Date *(dd,mm,yy)*

AUTHORIZATION OF PATIENT

I authorize the release to the Disability Management Institute (DMI) complete written reports covering diagnosis, treatment, prognosis and all other related medical information that is required as a result of my claim for Medical Absence Benefits. I authorize the Disability Management Institute to release relevant medical reports to the relevant medical professionals, medical related facilities, insurers and the Worker's Compensation Board. I authorize the Disability Management Institute and my Employer to exchange necessary information relative to my ability to return to work. A photocopy of this authorization will be as valid as the original.

Signature of Employee	Date

The patient is responsible for any charges made for completion of this form