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BFL Canada INC.

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ACCIDENT CLAIM REPORT

ATTENDING PHYSICIAN'S STATEMENT - HEALTH INSURANCE CLAIM

ACCIDENT

GROUP POLICY HOLDER	NAME OF YOUR CLUB	POLICY NUMBER	CERTIFICATE NO.
SPORT NL		6300010	N\A

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**