

April 28, 2020

To: Benefit Administrators / Human Resource Personnel

**From: Kyle Stroeder
Claims Services Manager, Employee Benefits**

Re: NEW! Disability Income Plan Application Form

Simplifying our forms is a commitment we made in year 1 of the Path to Health Claims Management Re-Design Project.

We are pleased to share with you the newly simplified Attending Physician's Initial Statement Disability Income Plan Application Form.

The new form is in a fillable pdf format and is available on our website www.3shealth.ca. The form can be filled out electronically or in hard copy, whichever the physician prefers. Once printed and signed, the completed form can be scanned and emailed to ebp@3shealth.ca or sent by regular mail.

We are enclosing a copy of the new form for reference. Please recycle any existing stock of the old form you may have on hand, including the disability application booklet.

We welcome your feedback on the new form! Please contact Kathryn Sandstra by telephone at 1-306-347-5598, or email us at ebp@3sHealth.ca with any questions or feedback on the new disability income plan application forms.

Dear Colleague,

I am writing to you on behalf of 3sHealth Employee Benefits in my capacity as consulting physician.

When healthcare system employees have an illness or injury that may impact their ability to work, they can apply for income and support from the Disability Income Plans administered by 3sHealth. The plans cover both In-Scope (union) and Out-of-Scope (non-union) employees. Employees are covered by specific plans which may differ depending on their union affiliation or Out-of-Scope status. However, the goal of all the plans is to ensure your patients receive appropriate treatment and accommodations that return them to functionality and gainful employment.

As a physician, you can help achieve this outcome in an important way. Your role as the attending physician supports your patient through the process and allows them to successfully return to work whenever possible.

I hope this package of information will help you and your patient navigate the Disability Income Plan claim process successfully.

Enclosed in this package:

1. Attending Physician's Initial Statement

This document supports the employee's application for disability benefits. It requires a disabling diagnosis and any co-morbid conditions which may impact recovery and return to function. It also requests information with respect to subjective symptoms and objective findings and a treatment plan, including further consultations or diagnostics planned or in progress. We ask that your comments also include your patient's work restrictions and limitations. It is most helpful when this information is fully documented and legible to allow for timely adjudication of the file.

It is helpful to remember that this form should be completed in keeping with the College of Physicians and Surgeons of Saskatchewan Policy on the Role of Physicians in Certifying Illness and/or Assessing Capacity for Work.

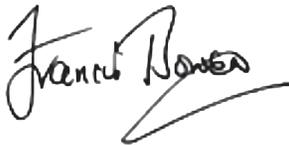
As the attending physician, do you support work accommodation? This is a frequent and important question. Reasonable accommodations are adjustments or modifications provided by an employer to enable people with disabilities to enjoy equal employment opportunities. A gradual return to work program can also be used to assist a patient to return to the workplace by an increase in hours and/or duties with the ideal to safely return the patient to their pre-disability level of work. Other questions, including whether you support work accommodation rather than disability leave and whether you support a graduated return to work, can impact the length of time it takes for your patient to return to work. Please note that all health system employers are encouraged to explore work modification and work accommodation for their employees. We believe that keeping the employee engaged in the workplace as their medical needs are addressed can provide a positive return to work experience for the patient when appropriate, without harm and without jeopardizing their safe return to work.

The Disability Income Plans administered by 3sHealth were formulated by all health system employers and the unions representing health system employees. The role of 3sHealth staff is to provide information and to process the claims according to the guidelines set out in the agreed upon plan policies and procedures. Requirements, such as the patient obligation to pay for reports, have been negotiated and agreed upon by a wide group of stakeholders, including employee representatives.

The role of medical consultants to 3sHealth is to review the medical information gathered and ensure the reported diagnosis, treatment plan and prognosis, as provided by you, the attending physician, fits with the objective information. If you are expecting variances from the typical recovery period for the stated diagnosis we can provide context or suggest what further information may be required to adjudicate the file.

If you have specific concerns or questions, please do not hesitate to contact us directly at any time.

Sincerely,



Dr. F. Bowen
Medical Consultant, Disability Income Plan

To be provided to your physician with the Attending Physicians Initial Statement.

Attending Physician's Initial Statement Disability Income Plan Benefits

TO BE COMPLETED BY EMPLOYEE

PLAN MEMBER INFORMATION

First Name	Last Name	Date of Birth	dd/mm/yy	Benefit ID#
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PATIENT AUTHORIZATION

I authorize all physicians and medical practitioners involved in the assessment, investigation and treatment of the medical condition(s) affecting my absence from work to provide 3sHealth with the information required for my Disability Income Plan benefits application.

Plan Member Signature	Date Signed	dd/mm/yy
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TO BE COMPLETED BY THE PHYSICIAN

DIAGNOSIS

Primary	Date of diagnosis	dd/mm/yy
Secondary	Date of diagnosis	dd/mm/yy
If the condition is related to pregnancy indicate the expected or actual delivery date		dd/mm/yy
Is this condition work related? <input type="checkbox"/> No <input type="checkbox"/> Yes, provide the date of injury		dd/mm/yy
Is this condition due to a motor vehicle accident? <input type="checkbox"/> No <input type="checkbox"/> Yes, provide the date of accident		dd/mm/yy

TREATMENT/CARE PLAN

Describe the current treatment program or care plan including the following (if applicable). Provide copies of all consultation reports and test results.

Names and dosages of medications and any reported side effects. If you require more room please attach a list <input type="checkbox"/> Medication list attached	Medication & dosage	Medication & dosage
	Side effects	Side effects
Details regarding concurrent treatments (e.g. physiotherapy, counselling etc.)		
Hospital admission date	dd/mm/yy	Hospital discharge date
		dd/mm/yy
Future plans for treatment		

PLAN MEMBER INFORMATION

First Name	Last Name	Date of Birth	dd/mm/yy	Benefit ID#
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FUNCTIONAL ABILITIES

What are the patient's objective restrictions and limitations?

Provide objective reasons to support your recommendations and provide any and all additional documentation that supports your patient's claim.

When do you expect the patient to return to work?

dd/mm/yy

NOTES TO THE PHYSICIAN

This form is designed to help compile the information necessary to determine your patient's eligibility for Disability Income Plan Benefits. It is important that these questions be answered comprehensively in order to accurately determine eligibility for benefits and, if the patient is eligible, to effectively manage their absence from and return to work. Incomplete information could result in difficulty determining your patient's eligibility for benefits and necessitate further inquiry.

PLEASE NOTE THAT 3sHEALTH WILL NOT COVER COSTS ASSOCIATED WITH THE COMPLETION OF THIS INITIAL APPLICATION FORM.

It is important that your patient apply for the appropriate type of income replacement benefit. Some employers are not aware of the cause of the employee's illness or injury. If you believe that your patient's medical condition is a direct result of a workplace injury, the patient should be advised to consult their employer about an application for Workers' Compensation Board benefits before proceeding with this application to 3sHealth.

Thank you for your assistance with this application process and management of your patient's absence from work.

Signature	Date Signed	dd/mm/yy
Please legibly print, type or stamp your name address and specialty	Telephone	
	Fax	
	E-Mail	