CHRONIC CARE / ALTERNATE LEVEL OF CARE

CLAIM FORM

HOW TO CLAIM: **1) This form must be completed in full by a Hospital Official and should be forwarded to our office (Att: Hospital Claims Department) after the month for which the co-payment fee applies.**

2) An assessment to determine eligibility for a reduced rate must be completed by a Hospital Official and copies of the results MUST be forwarded with the initial claim. The Hospital will have a supply of the assessment forms as they are provided by the Ministry of Health directly to the hospital.

Name of facility _____

Address _____

Patient's Green Shield Identification Number _____

Patient's Surname _____ Given Name _____ Birth Date _____/_____/_____

Date of Admission to: ☐ Chronic Care _____ ☐ ALC _____

Is this placement expected to be ☐ permanent ☐ for rehabilitation purposes only.

Is this claim the result of a Motor Vehicle Accident? ☐ Yes ☐ No

Are these benefits provided by any other insurer? ☐ Yes ☐ No

If yes, please provide insurance company name _____

If other coverage is Green Shield, indicate Green Shield number _____

Account for Period from _____ to _____

Monthly Co-payment Charge $_____ OR Rate per day $ _____ X _____ days = $ _____ (Rate per day calculation is for partial month billings only.)

Type of Accommodation occupied: ☐ Standard ☐ Semi-Private ☐ Private

If patient occupied a Semi-Private room, indicate applicable differential charge in addition to the co-payment:

$ _____ X _____ days = $ _____

Direction to Pay

If payment is to be issued directly to the facility, please indicate Green Shield Provider Number _____

If payment is to be issued to subscriber, please indicate the full mailing address to where the cheque should be sent.

_____

Certification of Hospital

We certify that the patient named above has resided in a Chronic Care/ALC bed for the period billed. An assessment to determine eligibility for a reduced rate (refer to Ministry of Health Rules & Guidelines) has been conducted and the charges indicated above take the assessment results into account.

Date_____ **Signature of Hospital Official** _____

By signing this claim form and/or submitting actual receipts, I agree that the information provided on this form is complete and accurate. I understand that the information provided by me to Green Shield Canada about myself and my dependants, will be used by Green Shield Canada for claims adjudication and any other services necessary in the administration of our benefits which may include the exchange of information with other parties to administer this benefit claim.

I am authorized by my spouse and/or dependants to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.

THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/SUBSCRIBER.
ALL CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS OF THE DATE OF SERVICE.

Send form to: **GREEN SHIELD CANADA**
PO Box 1615, Windsor, Ontario N9A 7J3

CUSTOMER SERVICE CENTRE 1-888-711-1119 or (519) 739-1133

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