GREEN SHIELD CANADA

P.O. Box 1615 Windsor, ON N9A 7J3
Customer Service Centre 1-888-711-1119 or (519) 739-1133

LONG-TERM CARE FACILITY CLAIM FORM

LTC FACILITY INFORMATION

LTC FACILITY NAME			GREEN SHIELD CANADA PROVIDER NO.
ADDRESS			
CITY	PROVINCE	POSTAL CODE	TELEPHONE NO. ( )

PATIENT INFORMATION

GREEN SHIELD I.D. NO.	DATE OF BIRTH _____/_____/_____ YEAR MONTH DAY
PATIENT SURNAME / GIVEN NAME(S)	

DATE OF ADMISSION TO LONG-TERM CARE FACILITY: _____

TYPE OF ACCOMMODATION OCCUPIED: STANDARD ☐ SEMI-PRIVATE ☐ PRIVATE ☐

Does the patient have any other group insurance coverage that may include these services as benefits? Yes ☐ No ☐
If yes, please provide insurance company name _____

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

BILLING INFORMATION

ACCOUNT FOR PERIOD FROM _____ TO _____ INCLUSIVE

INDICATE THE EXACT DATE OF DISCHARGE (if applicable) _____

PARTIAL MONTH BILLING

Co-Payment Rate Per Day $_____ X Number of Days Billed _____ = Total Amount Payable $_____

OR

MONTHLY CO-PAYMENT CHARGE = $_____

If patient discharged for any reason during period being claimed (hospital admission, extended vacation):

Date discharged from LTC facility: _____ Date returned to facility: _____

Reason for absence: _____

** **PAYMENT OF HOLDING DAYS WILL DEPEND ON THE INDIVIDUAL'S CONTRACTUAL BENEFIT.**

CERTIFICATION OF LONG-TERM CARE FACILITY

We certify that the patient has resided in this facility for the period indicated above. This Long-term Care Facility is licensed and funded by the provincial health governing body in the province of its location. The patient has been assessed by the applicable provincial placement service and has been deemed to qualify for admission to a long-tem care facility. (Proof of assessment, placement and income reduction applications are required with first claim submission).

_____ _____

Date (Year, Month, Day) **Signature of Long-Term Care Facility Official**

PAYMENT DIRECTION: Sign applicable box below

The charges listed on this claim have been paid in full.
PLEASE REIMBURSE SUBSCRIBER DIRECTLY.

_____
Authorized Facility Signature

MAILING ADDRESS FOR SUBSCRIBER'S CHEQUE:

_____

_____

The charges listed on this claim are outstanding. Signature of LTC Facility Official signifies that the patient or their agent has authorized PAYMENT OF THIS CLAIM DIRECTLY TO THE FACILITY.

_____
Authorized Facility Signature

By signing this claim form and/or submitting actual receipts, I agree that the information provided is complete and accurate, to the best of my knowledge. I authorize Green Shield Canada to exchange information with other parties as required and only when the information is needed to administer this benefit claim and/or to confirm the accuracy of this information.

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.**