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 (Attn: 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 _____ / _____ / _____
Year Month Day

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 plan member, please indicate the full mailing adress to which the cheque should be sent.

_____

Certification of Hospital

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

Date _____ **Signature of Hospital Official** _____

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

By signing this claim form and/or submitting actual receipts, I agree that the information provided is complete and accurate. I understand that the information provided by me to Green Shield Canada about myself and my dependents, 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 further authorize Green Shield Canada to obtain and exchange information with other parties, such as health practitioners or insurers, in order to confirm the accuracy of the submitted claim(s) information. In the event of suspected fraudulent activity pertaining to claims submitted on behalf of myself and/or my dependents, I acknowledge and agree to the disclosure of this information to relevant parties, such as the Plan Sponsor, regulatory and law enforcement agencies.

THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/PLAN MEMBER.
ALL CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS OF THE DATE OF SERVICE (unless otherwise stated in your benefit plan documentation).

Send form to: **GREEN SHIELD CANADA**
P.O. BOX 1615, Windsor, Ontario N9A 7J3
CUSTOMER SERVICE CENTRE 1-888-711-1119 or (519) 739-1133