NO STAPLES PLEASE, PAPER CLIPS ONLY

GreenShield™ Insurance

CLAIM FORM FOR CHRONIC CARE / ALTERNATE LEVEL OF CARE

Please use one form per patient

SECTION 1 - FACILITY INFORMATION

FACILITY NAME			FACILITY PROVIDER NUMBER
ADDRESS			
CITY	PROVINCE	POSTAL CODE	FACILITY PHONE #

SECTION 2 - PATIENT INFORMATION

Plan Member ID:

Patient Name:

Date of Birth _____ / _____ / _____ (YY / MM / DD)

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 Canada Insurance, indicate Plan Member ID: _____

Is this claim the result of a motor vehicle accident? ☐ Yes ☐ No

SECTION 3 - BILLING INFORMATION

Date of admission to : ☐ **Chronic Care** _____ / _____ / _____ (YY / MM / DD) ☐ **Alternate Level of Care** _____ / _____ / _____ (YY / MM / DD)

Is this placement expected to be:

☐ **permanent** ☐ **for rehabilitation purposes only**

Account for period from _____ / _____ / _____ (YY / MM / DD) **to** _____ / _____ / _____ (YY / MM / DD)

PARTIAL MONTH BILLING

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

OR

Monthly Co-Payment Charge = $ _____

(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 Rate Per Day $ _____ **X Number of Days Billed** _____ **= Total Amount Payable $** _____

SECTION 4 - CERTIFICATION OF HOSPITAL

WE CERTIFY THAT THE PATIENT HAS RESIDED IN A CHRONIC CARE/ALC BED FOR PERIOD INDICATED ABOVE. 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**

SECTION 5 - AUTHORIZATION AND CONSENT

At Green Shield Canada Insurance ("**GreenShield**," "**we**," "**us**" or "**our**"), respecting and protecting the privacy and confidentiality of your personal information is a priority. In order to provide you with the services for which we have been engaged, we need you to understand, and consent to, a few things. We may collect/receive from you or other parties and use, share, disclose and process your personal information and, if applicable, that of your spouse, children and other dependents (collectively, "**you**" or "**your**"), which may include name, age, claims history, income, email address, service providers that may have been used and banking information. We may do this for various purposes related to the administration of your benefits plan and to provide you other products and services, including but not limited to: benefits coordination with other carriers; administration and adjudication of claims; auditing, investigating, and taking steps connected to the prevention or suppression of suspected or proven improper or fraudulent claims; identity checks; billing and collection of premiums; medical underwriting; communication with other service providers, communication with third parties to confirm the accuracy of claims, provide contracted services, or for health management purposes or programs; collecting information about services that are provided, analyzing data, including information on how you use our products and services, to help us make informed decisions and improve the products and services we offer; determining if there are other products and services that you might be interested in, and sending you details about them; compliance with applicable laws and regulations; and such other activities that a reasonable person would consider associated with the administration of your benefit plan. In carrying-out these purposes, we may collect, receive, share or disclose your personal information with others outside of GreenShield, including, but not limited to: your employer, sponsor(s) of your benefit plan, and insurance advisors, if your benefits are provided through your employer's group benefits plan; benefits providers (e.g. pharmacists, massage therapists); professional regulatory bodies (e.g. College of Pharmacists); government agencies; applicable law enforcement bodies (local, provincial and federal); industry drug pooling entities (e.g. Canadian Drug Insurance Pooling Corporation); GreenShield's third party service providers who assist us in administering your benefits plan and providing you with other related products and services and such other third parties as may be appropriate or reasonably necessary in carrying out the purposes set out above. Although sharing of personal information is inherently risky, we implement commercially-acceptable procedures to secure and protect your personal information using appropriate technological, physical and organizational measures designed to protect personal information. In the event of an unauthorized release by us of your personal information, we will notify you in accordance with applicable privacy laws. More information about our privacy practices is available in our Privacy Policy at www.greenshield.ca, which is a necessary and integral part of this privacy consent. We may from time to time revise our Privacy Policy to reflect changes in, for example, legislation or regulation, or as we introduce new features, products or services. The most current version of the policy will govern how we process your personal data and will always be available on www.greenshield.ca. You can contact our Privacy Officer at privacy.office@greenshield.ca if you have a question or complaint.

By signing below, you are providing your consent to GreenShield's collection, use and disclosure of your personal information as explained above, and you are acknowledging that you are authorized by your spouse, children and other dependents (if applicable) to disclose and receive their personal information, and to provide this privacy consent on their behalf. You agree that a photocopy, facsimile or electronic version of this consent will be as valid as the original. You can withdraw your consent at any time by providing notice in writing to GreenShield at privacy.office@greenshield.ca, but, if you do so, GreenShield will no longer be able to administer your benefits plan and process your claims.

Name	Signature	Date

SECTION 6 - ASSIGNMENT OF BENEFITS

THE CHARGES LISTED ON THIS CLAIM ARE OUTSTANDING. SIGNATURE OF FACILITY OFFICIAL SIGNIFIES THAT THE PATIENT OR THEIR AGENT HAS AUTHORIZED PAYMENT DIRECTLY TO THE FACILITY.	**THE CHARGES LISTED ON THIS CLAIM HAVE BEEN PAID IN FULL. PLEASE REIMBURSE PATIENT DIRECTLY.**
SIGNATURE OF PATIENT OR LEGAL GUARDIAN	**AUTHORIZED HOSPITAL SIGNATURE**

SECTION 7 - MAILING INSTRUCTIONS

ALL CLAIMS MUST BE RECEIVED WITHIN 12 MONTHS OF THE DATE OF SERVICE (unless otherwise stated in your benefit plan documentation).
PLEASE ATTACH ALL ORIGINAL CORRESPONDENCE and retain copies for your files as original receipts will not be returned.
The cost, if any, of obtaining this information is at the expense of the Patient/Plan Member.

EHS DEPARTMENT
P.O. BOX 1615
WINDSOR, ON
N9A 7J3

CUSTOMER SERVICE CENTRE 1-888-711-1119 or (519) 739-1133 **greenshield.ca**

SECTION 8 - 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