P. O. BOX 1615
Windsor, Ontario N9A 7J3
Attn: EHS Department
Customer Service Centre 1-888-711-1119 or (519) 739-1133

HOSPITALIZATION CLAIM FORM

HOSPITAL INFORMATION

Hospital Provider No.:_____ Patient's Hospital File No.:_____

Hospital Name:_____

Hospital Address:_____

Hospital Type: ☐ General ☐ Chronic ☐ Convalescent/Rehab ☐ Other

PATIENT INFORMATION

Green Shield Identification No.:_____

Patient Name:_____ Date of Birth:_____ / _____ / _____

Plan Member's Name:_____

Patient's Relationship to Plan Member:_____

Does the Patient have any other semi-private/private room coverage? ☐ Yes ☐ No

If yes, please complete: Policy No._____ Name of Insurer or plan_____

If other coverage is Green Shield, indicate Green Shield number_____

Was Hospitalization required due to a motor vehicle accident? ☐ Yes ☐ No

BILLING INFORMATION

	No. of Days	Daily Rate	Admission Date	Discharge Date	Room Type A - Active/Acute R - Rehab CH - Chronic/Continuing ALC - Alternate Level Care	Total Amount Claimed
Semi-Private Room (Maximum 2 Beds)						
*** Private Room (Maximum 1 Bed)**						

*** If patient had private room, please enter semi-private daily rate $_____**

DATE _____ **AUTHORIZED HOSPITAL SIGNATURE** _____

ASSIGNMENT

I CERTIFY THAT THE ABOVE INFORMATION IS ACCURATE. THE ROOM TYPE BEING BILLED WAS REQUESTED BY THE PATIENT. I HEREBY ASSIGN TO THE ABOVE HOSPITAL ALL OF THE HOSPITALIZATION BENEFITS PROVIDED BY MY SAID HOSPITAL INSURANCE OR SO MUCH THEREOF AS MAY SERVE TO SATISFY MY INDEBTEDNESS OR THAT OF MY DEPENDENT TO THE SAID HOSPITAL THIS PERIOD OF HOSPITALIZATION.

DATE _____ **PLAN MEMBER/EMPLOYEE** _____

AUTHORIZATION

I HEREBY AUTHORIZE ABOVE NAMED HOSPITAL TO RELEASE THE INFORMATION REQUESTED ON THIS FORM

DATE _____ **PATIENT OR PARENT, IF MINOR** _____

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).