GreenShield Insurance

P.O. BOX 1623 WINDSOR, ONTARIO N9A 7B3
Attn: EHS Department (519)739-1133 or
Customer Service Centre 1-888-711-1119

MULTIPLE PLAN MEMBER HOSPITALIZATION FORM

PROVIDER INFORMATION

Provider No

Telephone No. ( )

Name

Street Address

City Province Postal Code

Hospital Type ☐ General ☐ Chronic ☐ Conv/Rehab ☐ Other

PROVIDER NO. MUST BE INCLUDED OR CLAIM WILL BE RETURNED.THIS FORM IS ONLY TO BE USED FOR GREENSHIELD PLAN MEMBERS AND DEPENDENTS WHO ARE ADMITTED TO HOSPITAL AND REQUEST AND OCCUPY A SEMI-PRIVATE OR PRIVATE ROOM. INFORMATION SUBMITTED AND PAYMENTS MADE ARE SUBJECT TO AUDIT.

ATTENTION ADMINISTRATOR:ADMINISTRATOR CONFIRMS THAT ALL INFORMATION IS CORRECT AND GREEN SHIELD CANADA INSURANCE RESERVES THE RIGHT TO REDUCE ANY FURTHER CLAIMS IF IT LEARNS THROUGH AN AUDIT THAT THE INFORMATION IS INCORRECT.

** MVA MOTOR VEHICLE ACCIDENT

THIS FORM IS INTENDED FOR USE TO FACILITATE CLAIMS PROCEDURES. PAYMENT WILL BE MADE FOLLOWING RECEIPT OF COMPLETED FORM.

** MVA Y/N	Patient Identification No.	Full Name of Patient	Date of Admission			Date of Discharge			Patient Register No.	Days of Benefits	Rate per Day	Amount Claimed	ROOM TYPE A - Active R - Rehab CH - Chronic Continueing Care ALC - Alternate Level Care	
			YR	MO	DY	YR	MO	DY					Semi-Private (2 Beds)	Private (1 Bed)
												TOTAL		
												TOTAL		

I HEREBY CERTIFY THAT THE DAYS BILLED HEREIN WERE PROVIDED IN PREFERRED ACCOMODATIONS (AS RATED BY O.H.S.C.) TO THE PLAN MEMBER OR DEPENDENT WHOSE NAME APPEARS ABOVE.

_____ Period Ending_____

Signature of Authorized 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 Insurance about myself and my dependents, will be used by Green Shield Canada Insurance 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 Insurance 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.