MULTIPLE PLAN MEMBER LONG TERM CARE FACILITY FORM

PROVIDER INFORMATION

Name	Provider No	Telephone No. ( )
Street Address	Billing for Month of_____, Year_____	
City Province Postal Code	* TYPE OF ACCOMODATION: (Please Indicate) S - STANDARD SP - SEMI-PRIVATE P - PRIVATE	

RESIDENT INFORMATION

PLAN MEMBER NO.	SURNAME	GIVEN NAME	YEAR OF BIRTH	DATE OF ADMISSION			DATE OF DISCHARGE			* (See above note)	RATE PER DAY	NO. DAYS BILLED	TOTAL AMOUNT PAYABLE
				YR	MO	DAY	YR	MO	DAY				

By signing this claim form and/or submitting actual receipts, I agree that the information provided on this form 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

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.

*** NOTE:**PAYMENT OF HOLDING DAYS WILL DEPEND ON THE INDIVIDUAL'S CONTRACTUAL BENEFIT. IF PATIENT DISCHARGED FOR ANY REASON DURING PERIOD BEING CLAIMED (HOSPITAL ADMISSION, EXTENDED VACATION), YOU MUST INDICATE THE REASON AND THE DATE DISCHARGED FROM AND THE DATE RETURNED TO THE LTC FACILITY

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-term 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 _____

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

GREEN SHIELD CANADA
P.O. BOX 1615 WINDSOR, ONTARIO N9A 7J3
(519) 739-1133 OR CUSTOMER SERVICE CENTRE 1-888-711-1119