

HOSPITALIZATION CLAIM FORM

PO Box 1615, Windsor, ON N9A 7J3

CUSTOMER SERVICE CENTRE 1-888-711-1119 or (519) 739-1133

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: ____/____/____

Subscriber's Name: _____

Patient's relationship to subscriber: _____

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 CARE 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 _____ SUBSCRIBER/EMPLOYEE _____

AUTHORIZATION

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

DATE _____ PATIENT OR PARENT, IF MINOR _____

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

THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/SUBSCRIBER.
ALL CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS OF THE DATE OF SERVICE.