

LONG-TERM CARE FACILITY CLAIM FORM

LTC FACILITY INFORMATION			
LTC FACILITY NAME		GREEN SHIELD CANADA PROVIDER NO.	
ADDRESS			
CITY	PROVINCE	POSTAL CODE	TELEPHONE NO. ()
PATIENT INFORMATION			
GREEN SHIELD I.D. NO.		DATE OF BIRTH _____/_____/_____ YEAR MONTH DAY	
PATIENT SURNAME / GIVEN NAME(S)			
DATE OF ADMISSION TO LONG-TERM CARE FACILITY: _____			
TYPE OF ACCOMMODATION OCCUPIED: STANDARD <input type="checkbox"/> SEMI-PRIVATE <input type="checkbox"/> PRIVATE <input type="checkbox"/>			
Does the patient have any other group insurance coverage that may include these services as benefits? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes, please provide insurance company name _____			
If other coverage is Green Shield, indicate Green Shield number _____			
BILLING INFORMATION			
ACCOUNT FOR PERIOD FROM _____ TO _____ INCLUSIVE			
INDICATE THE EXACT DATE OF DISCHARGE (if applicable) _____			
PARTIAL MONTH BILLING			
Co-Payment Rate Per Day \$ _____ X Number of Days Billed _____ = Total Amount Payable \$ _____			
OR			
MONTHLY CO-PAYMENT CHARGE = \$ _____			
If patient discharged for any reason during period being claimed (hospital admission, extended vacation):			
Date discharged from LTC facility: _____ Date returned to facility: _____			
Reason for absence: _____			
** PAYMENT OF HOLDING DAYS WILL DEPEND ON THE INDIVIDUAL'S CONTRACTUAL BENEFIT.			
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 _____	
PAYMENT DIRECTION: Sign applicable box below			
<p>The charges listed on this claim have been paid in full. PLEASE REIMBURSE PLAN MEMBER DIRECTLY.</p> <p>_____ Authorized Facility Signature</p> <p>MAILING ADDRESS FOR PLAN MEMBER'S CHEQUE:</p> <p>_____</p> <p>_____</p>		<p>The charges listed on this claim are outstanding. Signature of LTC Facility Official signifies that the patient or their agent has authorized PAYMENT OF THIS CLAIM DIRECTLY TO THE FACILITY.</p> <p>_____ Authorized Facility Signature</p>	
By signing this claim form and/or submitting actual receipts, I agree that the information provided is complete and accurate, to the best of my knowledge. I authorize Green Shield Canada to exchange information with other parties as required and only when the information is needed to administer this benefit claim and/or to confirm the accuracy of this information.			
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).	