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: _____/_____/_____

Plan Member'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 ______________________ PLAN MEMBER/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/PLAN MEMBER.
ALL CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS OF THE DATE OF SERVICE (unless otherwise stated in your benefit plan documentation).