

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 SUBSCRIBER DIRECTLY.</p> <p>_____ Authorized Facility Signature</p> <p>MAILING ADDRESS FOR SUBSCRIBER'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/subscriber. | | All claims must be submitted within 12 months of the date of service. | |