NO STAPLES PLEASE, PAPER CLIPS ONLY

# CLAIM FORM FOR LONG-TERM CARE FACILITY

**Please use one form per patient**

## SECTION 1 - LTC FACILITY INFORMATION

| LTC FACILITY NAME | | | LTC FACILITY PROVIDER NUMBER |
|---|---|---|---|
| ADDRESS | | | |
| CITY | PROVINCE | POSTAL CODE | LTC FACILITY PHONE # |

## SECTION 2 - PATIENT INFORMATION

**Green Shield Number:**

| Patient Name: | Date of Birth _____ / _____ / _____ (YY / MM / DD) |
|---|---|

**Does the patient have any other group insurance coverage that may include these services as benefits?** ☐ Yes ☐ No

**If yes, please provide insurance company name:** _____

**If other coverage is Green Shield Canada, indicate Green Shield Number:** _____

## SECTION 3 - BILLING INFORMATION

**Date of admission to long-term care facility:** _____ / _____ / _____ (YY / MM / DD)

**Type of accommodation occupied:** ☐ Standard ☐ Semi-Private ☐ Private

**Account for period from** _____ / _____ / _____ (YY / MM / DD) **to** _____ / _____ / _____ (YY / MM / DD) **inclusive**

**Indicate the exact date of discharge (if applicable):** _____ / _____ / _____ (YY / MM / DD)

**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:** _____ / _____ / _____ (YY / MM / DD) **Date returned to facility:** _____ / _____ / _____ (YY / MM / DD)

**Reason for absence:** _____

**** PAYMENT OF HOLDING DAYS WILL DEPEND ON THE INDIVIDUAL'S CONTRACTUAL BENEFIT.**

## SECTION 4 - CERTIFICATION OF LONG-TERM CARE FACILITY

**WE CERTIFY THAT THE PATIENT HAS RESIDED IN THIS FACILITY FOR HTE 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 QUALITY FOR ADMISSION TO A LONG-TERM CARE FACILITY. (PROOF OF ASSESSMENT, PLACEMENT AND INCOME REDUCTION APPLICATIONS ARE REQUIRED WIHT FIRST CLAIM SUBMISSION).**

_____ _____

**DATE** **SIGNATURE OF LONG-TERM CARE FACILITY OFFICIAL**

## SECTION 5 - AUTHORIZATION AND CONSENT

At Green Shield Canada ("**GSC**," "**we**," "**us**" or "**our**"), respecting and protecting the privacy and confidentiality of your personal information is a priority. In order to provide you with the services for which we have been engaged, we need you to understand, and consent to, a few things. We may collect/receive from you or other parties and use, share, disclose and process your personal information and, if applicable, that of your spouse, children and other dependents (collectively, "**you**" or "**your**"), which may include name, age, claims history, income, email address, service providers that may have been used and banking information. We may do this for various purposes related to the administration of your benefits plan and to provide you other products and services, including but not limited to: benefits coordination with other carriers; administration and adjudication of claims; auditing, investigating, and taking steps connected to the prevention or suppression of suspected or proven improper or fraudulent claims; identity checks; billing and collection of premiums; medical underwriting; communication with other service providers, communication with third parties to confirm the accuracy of claims, provide contracted services, or for health management purposes or programs; collecting information about services that are provided, analyzing data, including information on how you use our products and services, to help us make informed decisions and improve the products and services we offer; determining if there are other products and services that you might be interested in, and sending you details about them; compliance with applicable laws and regulations; and such other activities that a reasonable person would consider associated with the administration of your benefit plan. In carrying-out these purposes, we may collect, receive, share or disclose your personal information with others outside of GSC, including, but not limited to: your employer, sponsor(s) of your benefit plan, and insurance advisors, if your benefits are provided through your employer's group benefits plan; benefits providers (e.g. pharmacists, massage therapists); professional regulatory bodies (e.g. College of Pharmacists); government agencies; applicable law enforcement bodies (local, provincial and federal); industry drug pooling entities (e.g. Canadian Drug Insurance Pooling Corporation); GSC's third party service providers who assist us in administering your benefits plan and providing you with other related products and services and such other third parties as may be appropriate or reasonably necessary in carrying out the purposes set out above. Although sharing of personal information is inherently risky, we implement commercially-acceptable procedures to secure and protect your personal information using appropriate technological, physical and organizational measures designed to protect personal information. In the event of an unauthorized release by us of your personal information, we will notify you in accordance with applicable privacy laws. More information about our privacy practices is available in our Privacy Policy at www.greenshield.ca, which is a necessary and integral part of this privacy consent. We may from time to time revise our Privacy Policy to reflect changes in, for example, legislation or regulation, or as we introduce new features, products or services. The most current version of the policy will govern how we process your personal data and will always be available on www.greenshield.ca. You can contact our Privacy Officer at privacy.office@greenshield.ca if you have a question or complaint.

**By signing below, you are providing your consent to GSC's collection, use and disclosure of your personal information as explained above, and you are acknowledging that you are authorized by your spouse, children and other dependents (if applicable) to disclose and receive their personal information, and to provide this privacy consent on their behalf. You agree that a photocopy, facsimile or electronic version of this consent will be as valid as the original. You can withdraw your consent at any time by providing notice in writing to GSC at privacy.office@greenshield.ca, but, if you do so, GSC will no longer be able to administer your benefits plan and process your claims.**

| Name | Signature | Date |
|---|---|---|
| | | |

## SECTION 6 - ASSIGNMENT OF BENEFITS

| | |
|---|---|
| **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.** | **THE CHARGES LISTED ON THIS CLAIM HAVE BEEN PAID IN FULL. PLEASE REIMBURSE PATIENT DIRECTLY.** |
| **AUTHORIZED FACILITY SIGNATURE** | **AUTHORIZED FACILITY SIGNATURE** |

## SECTION 7 - MAILING INSTRUCTIONS

**ALL CLAIMS MUST BE RECEIVED WITHIN 12 MONTHS OF THE DATE OF SERVICE (unless otherwise stated in your benefit plan documentation).**
**PLEASE ATTACH ALL ORIGINAL CORRESPONDENCE and retain copies for your files as original receipts will not be returned.**
**The cost, if any, of obtaining this information is at the expense of the Patient/Plan Member.**

**EHS DEPARTMENT**
P.O. BOX 1615
WINDSOR, ON
N9A 7J3

**CUSTOMER SERVICE CENTRE 1-888-711-1119 or (519) 739-1133** **greenshield.ca**