



# CLAIM FORM FOR HOSPITALIZATION

Please use one form per patient

## SECTION 1 - HOSPITAL INFORMATION

HOSPITAL PROVIDER NUMBER	PATIENT'S HOSPITAL FILE NUMBER	
HOSPITAL NAME	HOSPITAL PHONE #	
ADDRESS		
CITY	PROVINCE	POSTAL CODE
HOSPITAL TYPE: <input type="checkbox"/> General <input type="checkbox"/> Chronic <input type="checkbox"/> Convalescent/Rehab <input type="checkbox"/> Other		

## SECTION 2 - PATIENT INFORMATION

Plan Member ID:	
Patient Name:	Date of Birth <span style="float: right;">____ / ____ / ____ YY      MM      DD</span>
Plan Member's Name:	
Patient's relationship to plan member:	
Does the patient have any other semi-private/private room coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please complete:	
Policy Number: _____	Name of insurer or plan: _____
If other coverage is Green Shield Canada Insurance, indicate Plan Member ID: _____	
Was hospitalization required due to a motor vehicle accident? <input type="checkbox"/> Yes <input type="checkbox"/> No	

## SECTION 3 - BILLING INFORMATION

	No. of Days	Daily Rate	Admission Date (YY/MM/DD)	Discharge Date (YY/MM/DD)	Room Type A - Active/Acute R - Rehab CH - Chronic/Continuing 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 \$ \_\_\_\_\_

I certify that the room type being billed was requested by the patient and all information provided on this form is accurate.

\_\_\_\_\_  
DATE AUTHORIZED HOSPITAL SIGNATURE

## SECTION 4 - AUTHORIZATION TO RELEASE

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

\_\_\_\_\_  
DATE SIGNATURE OF PATIENT OR LEGAL GUARDIAN

**SECTION 5 - AUTHORIZATION AND CONSENT**

At Green Shield Canada Insurance ("GreenShield," "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 GreenShield, 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); GreenShield'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](http://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](http://www.greenshield.ca). You can contact our Privacy Officer at [privacy.office@greenshield.ca](mailto:privacy.office@greenshield.ca) if you have a question or complaint.

By signing below, you are providing your consent to GreenShield'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 GreenShield at [privacy.office@greenshield.ca](mailto:privacy.office@greenshield.ca), but, if you do so, GreenShield will no longer be able to administer your benefits plan and process your claims.

Name

Signature

Date

**SECTION 6 - ASSIGNMENT OF BENEFITS**

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.

THE CHARGES LISTED ON THIS CLAIM HAVE BEEN PAID IN FULL BY THE PATIENT. PLEASE REIMBURSE PATIENT DIRECTLY.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

AUTHORIZED HOSPITAL 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](http://greenshield.ca)