

To the Patient: The details requested below are mandatory in order for Green Shield to determine our liability with respect to this request. For prior approval, please forward this form to the address indicated below. A response letter outlining our liability will be forwarded to the patient promptly. Our decision is not intended to interfere with or reflect upon the course of treatment recommended by your doctor. Failure to request pre-approval may result in a denial of your claim.

SECTION 1 - MUST BE COMPLETED IN FULL BY THE PATIENT/GUARDIAN

Patient's Name _____ Date of Birth ____ / ____ / ____ Age _____

Address _____ * Green Shield Identification No. _____

_____ Telephone No. _____

Contact Person _____ Case Manager _____ Telephone No. _____

Do you have any other coverage that would cover these services? Yes No

If yes, please provide insurance Company name _____

If other coverage is Green Shield, indicate Green Shield number _____

SECTION II - MUST BE COMPLETED IN FULL BY PHYSICIAN

- I, as the attending physician, hereby authorize services for Nursing Care ____ Trained Attendant ____ Homemaker ____ for the above named patient.
- Patient diagnosis (please be specific) _____
- Special care and treatment to be rendered (indicate duties to be performed, including any complications or extenuating circumstances, special equipment that needs to be monitored, medications to be administered and whether they are being administered on a regular or a PRN basis, orally or by injection, intramuscular or subcutaneous). PLEASE BE SPECIFIC.

- Starting date of care: _____.
- Expected duration of need for these services _____ Week(s) _____ Months _____ 1 Year
- Number of hours **PER DAY** that these services are required: _____
- Number of days per week _____.
- Are these services required in the patient's home? Yes ____ No ____
- Are the services being requested in addition to those being provided under any Government funded programs (ie. Ontario - Home Care)? Yes ____ No ____
If yes, attach a letter outlining what services are being provided. If no, please specify reason. _____

- Hours per day _____ Level of Care (RN, RPN) _____ Name of Agency _____
- If Nursing Care is being requested, please provide reasons why someone with lesser qualifications could not accommodate these needs _____

- Are these services required due to a work related accident? Yes ____ No ____
- Are these services required due to a motor vehicle accident? Yes ____ No ____

PHYSICIAN'S SIGNATURE

DATE

PHYSICIAN'S NAME (PLEASE PRINT)

PHYSICIAN'S PHONE NUMBER _____

THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/SUBSCRIBER.

GREEN SHIELD CANADA

P.O. BOX 1699, WINDSOR, ONTARIO N9A 7G6

ATTENTION: EHS DEPARTMENT

CUSTOMER SERVICE CENTRE 1-888-711-1119 or (519) 255-1133