Green Shield CANADA

HOSPITALIZATION CLAIM FORM

PO Box 1615, Windsor, ON N9A 7J3
CUSTOMER SERVICE CENTRE 1-888-711-1119 or (519) 255-1133

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: ____/____/____

Subscriber'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 ____________ ____________

SUBSCRIBER/EMPLOYEE

AUTHORIZATION

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

____________ ____________

DATE PATIENT OR PARENT, IF MINOR

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