



CLAIM FOR HOSPITAL EXPENSES (NON-MEDICARE)

PART A: EMPLOYEE'S/CERTIFICATE HOLDER'S STATEMENT INSURANCE COMPANY/PLAN ADMINISTRATOR

Name		
Address (number, street, city, province, & postal code)		
EMPLOYEE/CERTIFICATE HOLDER		
Surname	Given Name	Date of Birth (day, month, year)
Address (number, street, city, province, & postal code)		Telephone No.
Relationship to Patient <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other		
Policy/Contract No.	Section/Division No.	Identification No. (Cert. or SIN No.)
Name of Employer		
PATIENT		
Surname	Given Name	Date of Birth (day, month, year)
Address		
Are any Hospital Benefits or Services provided under any other plan (e.g., Workers' Compensation, Spouse's Employer)? <input type="checkbox"/> No <input type="checkbox"/> Yes, please complete the following		
Policy No.	Name of Insurer/ Plan Administrator	Spouse's Date of Birth (dd/mm/yyyy)
Assignment I hereby assign to the Hospital named herein all benefits payable from this claim or so much thereof as may serve to satisfy my indebtedness or that of my Dependent.		
Date (day, month, year)	Employee's/Certificate Holder's Signature	
Authorization I authorize ClaimSecure, hospitals, healthcare professionals, insurers, administrators of government or other benefit plans, and other service providers working with ClaimSecure to exchange necessary information regarding this claim to administer my health benefit plan. I acknowledge that unless assigned to the service provider, any reimbursement of the above charges and explanation of such amounts paid will be provided to the benefit plan member.		
Date (day, month, year)	Patient's or Guardian's Signature	

PART B: HOSPITAL REFERENCE

Hospital Name		
Hospital Address (number, street, city, province & postal code)		
Hospital File No.	Name of Patient	
Admission Date (day, month, year)	Discharge Date (day, month, year)	Semi-Private Differential Daily
Type of Care Provided <input type="checkbox"/> Acute <input type="checkbox"/> Convalescent <input type="checkbox"/> Chronic <input type="checkbox"/> Other		Is confinement due to a work related accident or sickness? <input type="checkbox"/> Yes <input type="checkbox"/> No

PART C: HOSPITAL CHARGES NOT PAYABLE UNDER PROVINCIAL MEDICARE PLANS

Type	Days	Rate	Patient's Liability	Payment Due	Outstanding Balance
Semi-Private					
Private					
User Fee					
Other Charges (specify)					
Total Charges					
Hospital Authorization					
Date (day, month, year)			Authorized Hospital Signature		