

HOSPITAL BED ASSESSMENT FORM

Instructions for completion

This form must be completed in full to avoid delay in assessing the claim. Once we have all the required information and have assessed the information, we will notify the claimant, in writing, regarding plan coverage. Please ensure all fields are completed in pen using blue ink.

Part 1: Patient Information to be completed in full by the claimant

Patient name _____ Date of Birth:(d/m/y) _____

Phone number Home(____) _____ Work(____) _____

Group Number _____ Certificate Number _____

Are any health benefits or services provided under any other group insurance or health plan, Worker's Compensation or government plan?

Yes No if yes, what is the name of the other insurance agency? _____

Part 2: Provincial Funding to be completed in full by claimant

Coverage for Hospital Bed benefits through your ClaimSecure plan are supplemental to any services you are entitled to through your provincial assistive devices program. Please be sure to contact your provincial plan to verify eligibility before applying for Hospital Bed benefits with ClaimSecure.

Will a portion be covered by the provincial plan?: Yes No

If no please indicate the reason why? _____

Part 3: Name of Prescribing Physician

Physician name: _____

Address: _____

Phone number: (____) _____ Fax number: (____) _____

Physician Signature: _____

Part 4: Current Medical Information to be completed in full by physician

Diagnosis:

Prognosis:

What is the expected length of time the patient is required to use the hospital bed?

Length of time hospital bed will be required:

Part 5: Purchase and rental information to be completed by the supplier

Name of medical provider: _____

What is the rental cost per month for a:
Manual Hospital Bed _____ Electric Hospital Bed _____

What is the purchase cost:
Manual Hospital Bed _____ Electric Hospital Bed _____

Part 6: Authorization to be completed by the claimant

Release of Information:
I authorize the release of any information as requested in respect of this claim to ClaimSecure and certify that the information given on this form is true, correct and complete to the best of my knowledge.

Please note that any charge to obtain this information is the responsibility of the member. Furthermore, the completion of this form does not imply acceptance of the eligibility of coverage.

Plan member name: _____

Signature: _____ Date: _____

Once completed please return all completed documents enclosed to ClaimSecure Inc.

Mail to: CLAIMSECURE INC.
PO BOX 6500 STN A
SUDBURY ON P3A 5N5