

NURSING CARE 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) _____

Home phone number(____) _____ 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 Home Care Services to be completed in full by claimant

Nursing benefits through your ClaimSecure plan are supplemental to any services you are entitled to through your provincial home care plan. Please be sure to contact your home care plan before applying for nursing benefits with ClaimSecure.

Home care involvement: Yes No

If "Yes" how many hours per day/week are provided by the following health professional:

RN (registered nurse) _____ per day per week

LPN/RPN (licensed practical nurse/registered practical nurse) _____ per day per week

PSW (personal support worker) _____ per day per week

Case manager: _____ Phone number:(____) _____

Part 3: Current Medical Information to be completed in full by physician

Diagnosis:

History of medical condition: _____

Prognosis:

Reason nursing care is required and specific functions: _____

Condition: Acute Chronic Palliative

Condition: Unstable/Unpredictable Stable/Predictable

Level of care recommended: RN RPN/LPN

Length of time nursing care required: _____

Nursing services to be performed: In home

Out of Home

If out of home please specify: _____

Part 3: Name of Prescribing Physician

Physician name: _____

Address: _____

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

Physician Signature: _____ Date: _____

Part 4: Nursing care information to be completed by the RN, RPN, LPN or PSW

Name of RN, RPN, LPN or PSW: _____

License number and type of license: _____

Is the patient or member a relative? Yes No

If yes please indicate the nature of the relationship: _____

Part 5: 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