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: (dd/mm/yyyy)_____

Phone number: Home (_____) _____ Work (_____) _____

Group Number _____ Certificate Number _____

Email Address _____

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

I certify that the above information is true and complete and that the above charges were for goods and services received by me, my spouse or my eligible dependents. I certify that I am authorized to disclose and receive information about my spouse and/or dependents for purposes of assessing and paying a benefit if any. If I am submitting personal information about myself and/or my spouse and/or dependents, I acknowledge that I/he/she/we/they have reviewed and consent to the Disclaimer and Privacy Policy (https://www.claimsecure.com/privacy/). 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. I authorize ClaimSecure, 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 understand and agree that ClaimSecure will conduct audits of claims submitted by me for purposes including, but not limited to, preventing and detecting fraud. I authorize ClaimSecure, and persons acting for ClaimSecure, to disclose this claim, or any personal information contained in this claim, to the benefit plan sponsor/employer for the purposes of reporting fraud suspicious claims. I am aware that under certain circumstances permitted by law, ClaimSecure, or persons acting on its behalf, may be required or permitted to disclose this claim, and the information contained in this claim, including personal information, to others without my knowledge or consent, or the consent of the individual to whom the information relates. In all other circumstances, ClaimSecure will only disclose such personal information in accordance with ClaimSecure's Privacy Policy (https://www.claimsecure.com/privacy/). We may revise this Disclaimer from time to time, and will post the most current version on our website at https://www.claimsecure.com/. Please check back from time to time to ensure that you are aware of any changes and are using the most recent version of the Disclaimer. We will indicate at the top of the page the date this Disclaimer was last revised. Your continued use of our services after any such changes constitutes your acceptance of the Disclaimer as revised.

Plan member name _____

Signature _____ Date _____

Please complete and return with supporting documentation:

ClaimSecure, P.O. Box 6500 Station "A", Sudbury, Ontario P3A 5N5
Fax: 1-866-613-0530
Email: service@claimsecure.com
***Note: Do not staple or tape receipts to the claim form**