NURSING CARE ASSESSMENT FORM

Sponsor Information

This form must be completed in full to avoid delay in assessing the claim. Once we have all the required information and it has been reviewed, 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)_____

Day time phone number (_____) _____

Alternate phone number (_____) _____

Email address _____

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 the claimant)

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

Have you contacted the provincial plan: Yes ☐ No ☐

If Yes, complete parts 2A and 2B.

If no, why?

_____

_____

_____

Part 2A: Provincial Allocation by service (to be completed in full by the claimant)

Date of nursing assessment: _____

Date of next assessment: _____

Please indicate what type of home care involvement has been approved by the province including the amount of time below.

RN (registered nurse)

How many hours per day _____
How many days per week _____

LPN/RPN (licensed practical nurse/registered practical nurse)

How many hours per day _____
How many days per week _____

PSW (personal support worker)

How many hours per day _____
How many days per week _____

Other provincial medical allocation (if any) _____
_____

Case Manager _____ Phone Number : (_____) _____

Part 2B: Nursing care information (to be completed by nursing agency/facility)

Name of nursing care facility/ agency: _____

Address: _____

RN (registered nurse) cost per hour: _____

LPN/RPN (licensed practical nurse/registered practical nurse) cost per hour: _____

PSW (personal support worker) cost per hour: _____

Proposed date services would commence: _____

All nursing care providers must be licensed and in good standing in the province that they are practicing

Part 3: CurrentMedical Information (to be completed in full by physician)

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Physician name: _____

Address: _____

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

Physician Signature: _____ Date: _____

Physician stamp:

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 if any: 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 4: Authorization (to be completed in full 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**