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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 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 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.

Have you contacted the provincial plan: Yes ❑ No ❑

If Yes, complete parts 2A and 2B.

If no, why? _____

_____

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

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

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:_____

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Part 4: Authorization (to be completed by claimant)

Release of information:

I authorize ClaimSecure, healthcare professionals, insurers, administrators of government or other benefit plan, and other service providers working with ClaimSecure to release and exchange necessary information regarding this estimate/claim to administer my health benefit plan.

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 _____

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