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: Current Medical 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: Privacy Consent (to be completed in full by the claimant)

Protecting your personal information:
At ClaimSecure, we're committed to protecting personal information and respecting your privacy. Personal information is information that either on its own or combined with other information allows an individual to be identified. This includes your name and address, as well as more sensitive information such as your health and financial records. When applicable, this includes information about other people such as your spouse, common-law partner, and children.

How we use your personal information:
Your personal information is used to provide you with products and services and to improve our business operations. This includes verifying your identity, maintaining your profile, and informing you about features of the products you already have with us. It's also used to evaluate your eligibility for products, price our products collect feedback on our customer service, process claims, protect you and us from risks such as cyber threats and fraud, and comply with legal obligations. Your certificate number is used to link your products together and to keep your information separate from other customers with similar names.

Who we share personal information with:
We share your personal information with other people and organizations who help us administer your products and provide you with services. This may include your advisor or people who work with your advisor, and other organizations that provide us services such as paramedical examiners, medical laboratories, specialty coverage providers, independent medical examiners, and pharmacies. As well, we may share your information with travel assistance providers, technology suppliers, and insurance or reinsurance companies. As part of our day-to-day business, your personal information may be communicated to government departments and agencies and may be communicated outside your province of residence. We take protecting your personal information seriously and we'll never sell your personal information to anyone.

You're in control of your personal information:
We respect your privacy preferences and follow them when using your personal information. At any point in your relationship with us, you can choose how your personal information is used by submitting a request to our Privacy Office at privacy@claimsecure.com. This includes choosing whether you receive customer experience surveys, and whether you want to receive information and offers from ClaimSecure using the personal information we collect from you throughout your relationship with us. You can also exercise other privacy rights, such as access to or correction of your personal information, by emailing our Privacy Office at privacy@claimsecure.com.

If you choose to remove your consent to the collection, use and disclosure of the personal information required to serve you and meet our legal obligations, we may not be able to continue to provide you with products and services.

ClaimSecure uses personal information when making decisions related to products and services. These decisions may be made using automated processing.

Want to learn more? Please visit https://www.claimsecure.com/privacy-policy/.

Part 5: Authorizations and Declarations

I hereby:

1. Authorize ClaimSecure, any healthcare provider, my plan administrator, any insurance or reinsurance company, administrators of government benefits or patient support programs or other benefits programs, other organizations, or service providers working with ClaimSecure or any of the

foregoing, located inside or outside Canada, to exchange personal information when relevant and necessary for the adjudication of my claim(s).

2. Acknowledge that my personal information will be collected, used, and shared as set out above; and that refusing to consent may result in delay or denial of my request or ClaimSecure not being able to continue to provide me with products and services.

3. Acknowledge that ClaimSecure reserves the right to audit the information provided on this form at any time for purposes that include preventing and detecting fraud and this consent extends to any audit of my claim(s).

4. I authorize ClaimSecure, and persons acting for ClaimSecure, to disclose the information provided on this form to my benefit plan sponsor/employer for the purposes of reporting instances of fraud, waste or abuse suspected by ClaimSecure.

5. Confirm that, where the patient is a person other than myself, the patient has given their consent to provide their personal information and for ClaimSecure to use and disclose it as set out above.

6. Confirm that the information given is true, correct, and complete to the best of my knowledge. Failure to provide true, correct, and complete information on this form could result in a revocation of any approval decision, a requirement to repay paid claims or other appropriate action.

7. Acknowledge that unless assigned to the service provider, any reimbursement of the above charges and explanation of such amounts paid will be provided to me.

ClaimSecure may revise this Consent & Authorization 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 Consent & Authorization. Your continued use of our services after any such changes constitutes your acceptance of the Consent & Authorization 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

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