BLUE CROSS® CANASSURANCE

Claim Form
Hospital Allowance / Daily Compensation
Claimant's Statement

The form must be submitted to the insurer within 90 days of the discharge.

IDENTIFICATION

Claimant's Name: _____ Policy No.: _____

Date of Birth: _____ day/month/year _____ Public Health Insurance Card No.: _____

Address: _____

Home Phone: _____ Mobile: _____ E-mail: _____

Name of the policyholder: _____

HOSPITALIZATION INFORMATION

1. What is the reason of the hospitalization? ❑ injury ❑ illness ❑ pregnancy

2. When were you informed that you needed to be hospitalized? _____ day/month/year _____

3. In case of an illness, indicate the date the symptoms appeared: _____ day/month/year _____

4. In case of an accident, indicate the moment of the accident: _____ day/month/year _____ Time: _____ ❑ AM ❑ PM
   Location of accident (Indicate, if possible, street address and type of location: residence, public building, roadway, job site, etc.): _____
   _____
   Circumstances (Explain how the accident occurred): _____
   _____
   _____
   Name(s) of witnesses: _____
   _____
   Was a police report provided? ❑ Yes ❑ No If yes, please attach a copy.

5. Provide details on the injury or the name of the illness: _____
   _____

6. Date of the first treatment or of the first consultation for the illness: _____ day/month/year _____

7. Dates of hospitalization: from _____ day/month/year _____ to _____ day/month/year _____

8 Have you had surgery? ❑ Yes ❑ No If yes, please provide the date: _____ day/month/year _____
   Nature of the surgery: _____

9. During the hospitalization, have you been admitted in intensive care unit (ICU)? ❑ Yes ❑ No If yes, for how long? _____ days

10. Have you ever been treated for this illness or a similar condition? ❑ Yes ❑ No If yes, please provide:
    Name and address of the hospital: _____
    _____
    Hospital file number: _____ Reason of the hospitalization: _____
    Dates of hospitalization: from _____ day/month/year _____ to _____ day/month/year _____

STATEMENT

I hereby certify that the above information is, to the best of my knowledge, true and complete.

_____ _____ day/month/year _____
Signature of claimant Date

_____
Signature of the policyholder if claimant is less than 16 years of age in Ontario or less than 14 years of age in Québec.

Please read the IMPORTANT NOTICE on the back of the form.

IMPORTANT NOTICE

The forms gathered in this document are required when a claim is filed for the **Hospital Allowance** or **Daily Compensation** benefit.

All questions must be answered and the form must be submitted to the insurer within 90 days of the discharge.

CLAIMANT'S STATEMENT
- Sections IDENTIFICATION, HOSPITALIZATION INFORMATION and STATEMENT must be completed.
- The form HOSPITALIZATION CERTIFICATE must be completed and attached to the claim.

HOSPITALIZATION CERTIFICATE
- The section IDENTIFICATION must be completed by the insured person and the form must be completed by an authorized agent.
- Fees requested to complete this form are paid by the claimant.

Important
No comments must appear in the section completed by the agent and the notes must not be modified. To provide any details or comments to the information given, a separate sheet must be used.

AUTHORIZATION
- Read the content of the authorization carefully in order to understand the implications. This form will be used to collect the information required for the process of the claim or to disclose information to third parties.
- All three authorizations must be dated and signed in order to avoid any delay in the process.
- A blue ink ball point pen is preferable as some hospitals may mistake a form signed using black ink for a photocopy.

Forward the claim to the appropriate address according to your province of residence. For any questions, contact the Claims Department by telephone prior to forwarding the claim in order to avoid unnecessary delays. Calls to our Claims Department are recorded for training, quality control and verification purposes.

Blue Cross Canassurance
Claims, Individual Health Insurance
Telephone: 1-800-363-3958
Fax: 1-866-286-8358

Address in Ontario
P.O.Box 4433, Station A
Toronto, Ontario M5W 3Y7
Email: bco.indhealth@ont.bluecross.ca

Address in Québec
550 Sherbrooke St. West, Suite B9
Montréal, Québec H3A 3S3
Email: info@qc.bluecross.ca

BLUE CROSS® CANASSURANCE

Hospital Allowance / Daily Compensation

Hospitalization Certificate

It is the patient's responsibility to have this statement completed by an authorized agent.

PATIENT'S IDENTIFICATION (section to be completed by the claimant)

Last Name: _____ First Name: _____

Date of Birth: ____day/month/year____ Policy No.: _____ Public Health Insurance Card No.: _____

Hospital File No.: _____

HOSPITALIZATION INFORMATION

DIAGNOSIS

1. Primary: _____ Code CIM-9: _____

2. Secondary: _____ Code CIM-9: _____

3. Date of the first consultation for this condition: ____day/month/year____

INTENSIVE CARE UNIT (if applicable)

1. Admission date: ____day/month/year____ Time: _____ ❑ AM ❑ PM

2. Discharge date: ____day/month/year____ Time: _____ ❑ AM ❑ PM Number of days: _____

ACCUTE CARE

1. Admission date: ____day/month/year____ Time: _____ ❑ AM ❑ PM Type of accommodation: ❑ private ❑ semi-private ❑ ward

2. Discharge date: ____day/month/year____ Time: _____ ❑ AM ❑ PM Number of days: _____

LONG-TERM OR REHABILITATION CARE

1. Admission date: ____day/month/year____ Time: _____ ❑ AM ❑ PM Type of accommodation: ❑ private ❑ semi-private ❑ ward

2. Discharge date: ____day/month/year____ Time: _____ ❑ AM ❑ PM Number of days: _____

DAY SURGERY

1. Surgery date: ____day/month/year____ Location: ❑ out-patient unit ❑ clinic

HOSPITAL

Name of the hospital: _____

Type of facility: ❑ hospital center ❑ rehabilitation center ❑ hospital ❑ convalescent home

Address: _____

Name of signatory: _____ Function: _____

Signature: _____ Date: ____day/month/year____ Telephone: _____

STATEMENT

I hereby declare that the patient has been hospitalized and received the treatements mentioned above.

_____ _____

Name of the authorized agent, in block letters Telephone

_____ ____day/month/year____

Signature of the authorized person Date

Note: The claimant must pay any fees to complete this form.