iA Financial Group

Print

HOME CARE QUESTIONNAIRE

GROUP INSURANCE

Quebec
Group Health and Dental Claims
PO Box 800, Station Maison de la Poste
Montreal, Quebec H3B 3K6

All Other Provinces
Group Health and Dental Claims
PO Box 4643, Station A
Toronto, Ontario M5W 5E3

INSTRUCTIONS

1. The details requested below are required in order for Industrial Alliance Insurance and Financial Services Inc. (the "Company") to determine the eligibility of your request for reimbursement under the home care benefit. For prior approval, please forward this form to the address indicated above. You will then receive a confirmation letter from the Company concerning your request once the review has been completed.
2. In order to determine the eligibility of your request for reimbursement under the home care benefit, please have the patient's attending physician provide the information requested in the "TO BE COMPLETED BY THE ATTENDING PHYSICIAN" section which is on the reverse side of this form.
3. Some financial assistance programs are available for home care services. You must register for these programs, based on your territory, if the care is needed for more than two weeks.

Quebec residents:
- Integrated Health and Social Services Centres (CISSS)
- Local Community Services Centres (CLSC)

Other provinces residents:
- Community Care Access Centre (CCAC)
- Local Health Integration Networks (LHIN)

TO BE COMPLETED BY THE PLAN MEMBER (PLEASE PRINT CLEARLY)

1. PLAN MEMBER INFORMATION

Policy no. _____ Certificate no. _____

Plan member's name _____

Patient's name _____ Date of birth Y M D _____

Relationship to the plan member _____

2. COORDINATION OF BENEFITS

Are these fees covered by another insurance plan? ☐ No ☐ Yes

If yes, please provide the name of the policyholder _____

Name of the other insurance company _____ Contract no. _____

Protection: ☐ Family ☐ Single parent ☐ Individual ☐ Couple

3. NATURE OF FEES

Are the fees to be incurred for home care services related to:

A work accident? ☐ Yes ☐ No

A car accident? ☐ Yes ☐ No

Other, specify: _____

Date of accident: A M J _____

4. TRANSPORTATION FEES

During your recovery at home, will you need to travel to receive medical care or medical follow-up? ☐ No ☐ Yes

Which doctor(s) will you need to consult? _____

_____

Indicate the dates of the consultations

Y M D _____ Y M D _____ Y M D _____ Y M D _____ Y M D _____

Y M D _____ Y M D _____ Y M D _____ Y M D _____ Y M D _____

Note: Please provide a medical certificate from your doctor for each consultation and indicate the dates of the hospitalization period or the date of the day surgery. Fees are only reimbursed upon presentation of receipts (e.g., gasoline, bus, parking).

5. CHILD CARE FEES

During your recovery, will you incur child care fees that are in excess of those usually incurred? ☐ No ☐ Yes

Note: Please provide receipts clearly indicating the name of the child care service provider, including the address and telephone number.

6. PLAN MEMBER CONFIRMATION / AUTHORIZATION

If this questionnaire is being submitted in respect of my spouse or dependent child, **I CONFIRM that I am AUTHORIZED** to disclose information about him/her in regards to the home care services to be or being received.

I AUTHORIZE any healthcare provider or professional, medical organization, insurance or reinsurance company, workers' compensation board, the policyholder, my employer, as well as any other person, public or private organization or institution to disclose to Industrial Alliance Insurance and Financial Services Inc., its employees, agents and any service providers any information which they may need in the assessment of the information contained in this questionnaire in order to determine the eligibility for the home care benefit.

I AUTHORIZE the use of my Social Insurance Number as an identification number where required for administration of the group policy.

I AGREE that a photocopy of this Confirmation/Authorization shall be as valid as the original.

Patient's name _____ Date signed Y M D _____

Please have the attending physician complete and sign the reverse side of this form.

TO BE COMPLETED BY THE ATTENDING PHYSICIAN (PLEASE PRINT CLEARLY)

7. PATIENT CLINICAL INFORMATION

Please answer all the following questions

Was the patient hospitalized? ☐ No ☐ Yes

If yes, specify date of admission Y M D and date of discharge Y M D

Did the patient undergo day surgery? ☐ No ☐ Yes If yes, specify the date of surgery Y M D

Did the patient receive care/treatment in the emergency room? ☐ No ☐ Yes If yes, date of consultation at the emergency room Y M D

Length of stay under observation at the emergency room (number of hours) _____

The specific medical reasons that required hospitalization, surgery or one-day consultation at the emergency room _____

_____

_____

Please specify the nature of the surgery _____

_____

_____

What other health problem(s) does the patient have? _____

_____

_____

_____

_____

Description of care required _____

_____

_____

Name of home care service provider _____

Is he/she an immediate family member (spouse, mother, father, child, brother or sister of the insured)? ☐ No ☐ Yes

Address _____ Phone number

Period during which home care is required _____ hours / _____ days until Y M D

Description of services ☐ Hygiene ☐ Mobilization ☐ Weekly housekeeping

☐ Food ☐ Other _____

_____

Is the patient in the terminal phase of an illness? ☐ No ☐ Yes

7. PATIENT CLINICAL INFORMATION

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

Physician's name _____ Telephone

Address _____ Fax

General practitioner ☐ Specialist ☐ Other ☐ Specify _____

Signature _____ Date signed Y M D