MEDAVIE BLUE CROSS™

NURSING / PERSONAL CARE CLAIM FORM

PLEASE PRINT ALL INFORMATION.
PLEASE ATTACH ORIGINAL PAID-IN-FULL RECEIPTS FOR ALL SERVICES RENDERED.
FOR ADDRESSES OR INQUIRY NUMBERS PLEASE SEE REVERSE.

SECTION 1 - TO BE COMPLETED AND SIGNED BY THE PATIENT (PARENT / GUARDIAN)

MEMBER INFORMATION

Member Name: _____ ID Number: _____

Address: _____ Policy Number: _____

_____ Telephone Number: _____

Patient Name: _____ Date of Birth (dd/mm/yyyy): _____

Contact Name: _____ Contact Telephone Number: _____

Is the patient a resident of: ☐ Nursing Facility ☐ Special Care Home ☐ Not Applicable

Has your mailing address changed since your last claim? ☐ Yes ☐ No If Yes, signature of member is required for validation: _____

OTHER COVERAGE

Do you or any dependents have coverage under any other plan?

☐ **No** If applicable, please provide the Termination Date (dd/mm/yyyy): _____

☐ **Yes** **Complete the following:** Name of other Insurer: _____

Member Name: _____ ID Number: _____

Type of policy (✓): ☐ **Individual** ☐ **Group** Effective Date: _____ Policy Number: _____

Please indicate type of coverage (✓): ☐ Hospital ☐ Travel ☐ Extended Health ☐ Drugs ☐ Vision ☐ Dental ☐ **All**

MEMBER STATEMENT

This is to certify that the following is a true and correct statement of expense, that the nurse(s) / personal care attendant(s) listed herein is (are) not related to me or any member of my family and does (do) not reside in my household. I authorize the release of any information or records requested in respect of this claim to the insurer or its agents and certify that the information given is true, correct and complete to the best of my knowledge. **IMPORTANT: Please ensure that all information on this form is completed accurately before signing.**

I understand that the personal information provided herein, as well as any other personal information currently held or collected in the future by Medavie Blue Cross and/or Blue Cross Life Insurance Company of Canada, may be collected, used, or disclosed to administer the terms of my policy or the group policy of which I am an eligible member, to recommend suitable products and services to me, and to manage Blue Cross's business. Depending on the type of coverage I carry, limited personal information may be collected from and/or released to a third party. These third parties include other Blue Cross organizations, health care professionals or institutions, life and health insurers, government and regulatory authorities, the subscriber of any policy under which I am a participant and other third parties when required to administer and manage the benefits outlined in the policy of which I am an eligible member.

I understand that my personal information will be kept confidential and secure. I understand that I may revoke my consent at any time, however, in some instances doing so may prevent Blue Cross from providing me with the requested coverage or benefits. I understand why my personal information is needed and I am aware of the risks and benefits of consenting or refusing to consent to its disclosure.

I authorize Medavie Blue Cross to collect, use and disclose my personal information as described above.

Signature of Patient: _____ Date: _____

(If under 18 years of age, the signature of subscriber/parent/legal guardian is required.)

This consent complies with federal and provincial privacy laws. For additional information regarding privacy policies at Medavie Blue Cross, visit www.medavie.bluecross.ca or call 1-800-667-4511.

SECTION 2 - TO BE COMPLETED BY THE ATTENDING PHYSICIAN

DIAGNOSIS INFORMATION

Primary Diagnosis: _____

Other Pertinent Diagnosis: _____

Description of Prescribed Medical Services: _____

_____

_____

CERTIFICATE OF ATTENDING PHYSICIAN

I hereby certify that I prescribed private duty nursing / personal care service for the above named patient, due to the seriousness of the patient's illness.

Physican Name (Please Print): _____

Address: _____

Physician Signature: _____ Date: _____

SECTION 3 ON REVERSE PAGE TO BE COMPLETED BY NURSING/PERSONAL CARE PROVIDER

SECTION 3 - TO BE COMPLETED BY THE NURSING / PERSONAL CARE PROVIDER

PROVIDER INFORMATION

Agency Name (if applicable): _____ Provider Number: _____

Address: _____ Telephone Number: _____

The health care provider agrees that any person authorized by Medavie Blue Cross may have access to, take extracts from and make copies of any records respecting the provision of services provided to a participant and the cost of those services.

Signature of Provider: _____ Date: _____

REGISTERED NURSING / PERSONAL CARE CHARGES

*** Please indicate shift worked: (i.e. 0800 - 1600; 1600 - 2400; 2400 - 0800 hrs.)**

Provider Name	Designation (RN, RNA, LPN, PCW)	Registration Number	Date of Service			Shift * Start	Shift * Finish	Total # of Hours	Total Amount charged per shift	Location		
			DD	MM	YYYY					Home	Hosp.	Clinic or Other (Please Specify)

Description of Service Rendered

Nursing Care

Services Provided - Please indicate (✓) all services rendered:

- ❑ ADL's
- ❑ Bloodwork
- ❑ Dressings
- ❑ Meals / Housekeeping
- ❑ Supervision / Monitoring
- ❑ Injections
- ❑ Medication Administration
- ❑ Ostomy
- ❑ Custodial Care / Respite
- ❑ Shopping / Transportation
- ❑ Footcare
- ❑ Vitals
- ❑ Services in Hospital / Nursing Home

❑ Other (Please specify): _____

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644 Main Street PO Box 220
Moncton NB E1C 8L3
Inquiries: 1-800-667-4511

Dartmouth
230 Brownlow Avenue Dartmouth
PO Box 2200 Halifax NS B3J 3C6
Inquiries: 1-800-667-4511

Newfoundland & Labrador
66 Kenmount Road Suite 102
Kenmount Business Centre
St. John's NL A1B 3V7
Inquiries: 1-800-667-4511

Ontario
185 The West Mall Suite 1200
Etobicoke ON M9C 5P1
Inquiries: 1-800-355-9133

*** PLEASE ENSURE ALL AREAS ARE COMPLETE. INCOMPLETE INFORMATION MAY DELAY PROCESSING.**
*** PLEASE ATTACH ORIGINAL PAID-IN-FULL RECEIPTS FOR THE ABOVE SERVICES.**