Claim for Hospital Expenses (Non-medicare)

PART A: Employee's/Certificate Holder's Statement
Insurance Company/Plan Administrator

Name

Address (number, street, city, province, & postal code)

Employee/Certificate Holder

Surname	Given Name	Date of Birth (day, month, year)

Address (number, street, city, province, & postal code)

Relationship to Patient
☐ Self ☐ Spouse ☐ Parent ☐ Other

Policy/Contract No.	Section/Division No.	Identification No. (Cert. or SIN No.) - -

Name of Employer

Patient

Surname	Given Name	Date of Birth (day, month, year)

Address

Are any Hospital Benefits or Services provided under any other plan (e.g., Workers' Compensation, Spouse's Employer)?
☐ No ☐ Yes, please complete the following

Policy No.	Name of Insurer/ Plan Administrator	Spouse's Date of Birth

Assignment

I hereby assign to the Hospital named herein all benefits payable from this claim or so much thereof as may serve to satisfy my indebtedness or that of my Dependent

Date (day, month, year)	Employee's/Certificate Holder's Signature

Authorization

I hereby authorize the Hospital named herein to release the information requested on this form.

Date (day, month, year)	Patient's or Guardian's Signature

PART B: Hospital Reference

Hospital Name

Hospital Address (number, street, city, province & postal code)

Hospital File No.	Name of Patient	
Admission Date (day, month, year)	Discharge Date (day, month, year)	Semi-Private Differential Daily

Type of Care provided
☐ Acute ☐ Convalescent ☐ Chronic ☐ Other

Is confinement due to a work related accident or sickness?
☐ Yes ☐ No

PART C: Hospital Charges not payable under Provincial Medicare Plans

Type	Days	Rate	Patient's Liability	Payment Due	Outstanding Balance
Semi-Private					
Private					
User Fee					
Other Charges (specify)					
Total Charges					

Hospital Authorization

Date (day, month, year)	**Authorized Hospital Signature**