NURSING CARE ASSESSMENT FORM

Instructions for Completion: This form must be completed in full to avoid delay in assessing the claim. Once we have all the required information and have assessed the information, we will notify the claimant, in writing, regarding plan coverage. Please ensure all fields are completed in pen using blue ink.

1. PATIENT INFORMATION TO BE COMPLETED IN FULL BY THE CLAIMANT

YOU AND YOUR DEPENDENTS MUST BE INSURED UNDER YOUR PROVINCIAL HEALTH PLAN IN ORDER TO PARTICIPATE IN THIS GROUP INSURANCE PLAN.

DO YOU HAVE PROVINCIAL HEALTH COVERAGE? YES NO **DO YOUR DEPENDENTS HAVE PROVINCIAL HEALTH COVERAGE** YES NO

DO YOU HAVE COVERAGE THROUGH ANY OTHER INSURANCE PLAN? YES NO **IF YES, WHAT IS THE NAME OF THE PROVIDER?**_____

GROUP NUMBER	LOCAL UNION NUMBER	CERTIFICATE NUMBER

LAST NAME	FIRST NAME

PHONE NUMBER	EMAIL ADDRESS	DATE OF BIRTH (MM/DD/YY)

2. PROVINCIAL FUNDING (TO BE COMPLETED IN FULL BY CLAIMANT)

Nursing benefits through your plan are supplemental to any services you are entitled to through your provincial home care plan.

Please be sure to contact your home care plan before applying for nursing benefits.

Have you contacted the provincial plan? Yes No

If Yes, complete parts 2A and 2B.

If no, why? _____

2A. PROVINCIAL ALLOCATION BY SERVICE (TO BE COMPLETED IN FULL BY 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 _____

Other provincial medical allocation (if any)_____

_____

Case Manager:_____ Phone Number:_____

2B. NURSING CARE INFORMATION (TO BE COMPLETED IN FULL BY CLAIMANT)

Name of nursing care facility/ agency: _____

Address: _____

RN (registered nurse) cost per hour:_____

LPN/RPN (licensed practical nurse/registered practical nurse) 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****

Complete Next Page

3. Current Medical Information (to be completed by Physician)

Physician Name:

Address			**Phone**
City	**Province**	**Postal Code**	**Fax**

Signature: **Date:**

Physicians 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:_____

4. Authorization to be completed by the claimant

I authorize the release of any information as requested in respect of this claim to Ellement/FAS and the Insurer and certify that the information given on this form is true, correct and complete to the best of my knowledge.

Please note that any charge to obtain this information is the responsibility of the member. Furthermore, the completion of this form does not imply acceptance of the eligibility of coverage.

Plan Member Name: **Date**

(MM/DD/YY)

Signature of Member

Please complete and return with supporting documentation:

Ellement
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