

NURSING CARE QUESTIONNAIRE



Quebec

Group Health and Dental Claims PO Box 800, Station Maison de la Poste Montreal, Quebec H3B 3K5 **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. ("iA Financial Group") to determine the eligibility of your request for reimbursement under the nursing care benefit. For prior approval, please forward this form to the address indicated above. You will then receive a confirmation letter from iA Financial Group concerning your request once the review has been completed.
- 2. In order to determine the eligibility of your request for reimbursement under the nursing care benefit, please have the patient's attending physician provide the information requested in the "TO BE COMPLETED BY THE ATTENDING PHYSICIAN" section.
- 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. 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 the accident: Y M D	
3. PLAN MEMBER CONFIRMATION / AUTHORIZATION	
If this questionnaire is being submitted in respect of my spouse or dependent child, I Corregards to the nursing care services to be or being received.	ONFIRM that I am AUTHORIZED to disclose information about him/her in
I AUTHORIZE any healthcare provider or professional, medical organization, insurance my employer, as well as any other person, public or private organization or institution t employees, agents and any service providers any information which they may need in t to determine eligibility for the nursing care benefit.	to disclose to Industrial Alliance Insurance and Financial Services Inc., its
AUTHORIZE the use of my Social Insurance Number as an identification number when	re it is required for the administration of the group policy.
I AGREE that a photocopy of this Confirmation/Authorization shall be as valid as the or	
Plan member signature	Y M D Date signed

PLEASE COMPLETE AND SIGN THE REVERSE SIDE OF THIS FORM.

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

4. PATIENT CLINICAL INFORMATION	
Please provide a brief summary of the patient's condition/diagnosis requiring nursing care	
Prognosis	
Amount of care required: Hours per day Days per week	
Expected duration of care: From to to to to	
Level of care required: RN LPN Other If other, please specify	
Location where services will be provided: Home Hospital Other If other, please specify	
Type of medication, method of administration and frequency	
Specific duties to be performed by the nurse	
Additional comments	
5. PATIENT CLINICAL INFORMATION	
I hereby confirm that the above information is true and complete to the best of my knowledge.	
Physician's name	Telephone L
Address	Fax
General practitioner Specialist Other Specify	
Signature	Y M D Date signed L I I L L L L
orginature	Date signed

iA Financial Group is a business name and trademark of **Industrial Alliance Insurance and Financial Services Inc**.