iA Financial Group

NURSING CARE QUESTIONNAIRE

GROUP INSURANCE

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

Print

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 CONFIRM that I am AUTHORIZED** to disclose information about him/her in regards to the nursing 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 eligibility for the nursing care benefit.

I AUTHORIZE the use of my Social Insurance Number as an identification number where 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 original.

Plan member signature _____ Date signed Y M D _____

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 Y M D to Y M D

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

Address _____ Fax

General practitioner ☐ Specialist ☐ Other ☐ Specify _____

Signature _____ Date signed Y M D