AUTHORIZATION FORM FOR IN HOME SUPPORT SERVICES OF A REGISTERED NURSE, REGISTERED PRACTICAL NURSE, PERSONAL SUPPORT WORKER

www.ssq.ca
English: 418-651-2551 or Toll Free 1-888-651-8181
French: 418-651-2588 or Toll Free 1-877-651-8080
Fax Number: 1-855-453-3942

To the Patient: The details requested below are mandatory in order for SSQ Insurance to determine our liability with respect to this request. A response letter outlining our liability will be forwarded to the patient promptly. Our decision is not intended to interfere with or reflect upon the course of treatment recommended by your doctor. Failure to request pre-approval may result in a denial of your claim.

SECTION I - MUST BE COMPLETED IN FULL BY THE PARTICIPANT

Patient Name ______________________________

Address ______________________________

Telephone No. ______________________

Date of Birth ____/____/____ **Age**____

Height ________ **Weight** ________

SSQ certificate no ______________________

Participant Name ______________________

Do you have any other Group Insurance coverage that may include these services as benefits? ☐ Yes ☐ No

If Yes, please provide Insurance Company name______________________

If other coverage is SSQ, indicate certificate number______________________

SECTION II - MUST BE COMPLETED IN FULL BY PHYSICIAN

1) I, as the attending physician, hereby authorize services for R.N.______R.P.N.______Personal Support Worker______for the above named patient.

2) Patient diagnosis (please be specific)______________________

3) **Special care and treatment to be rendered (indicate duties to be performed, including any complications or extenuating circumstances, special equipment that needs to be monitored, medications to be administered and whether they are being administered on a regular or a PRN basis, orally or by injection, intramuscular or subcutaneous). PLEASE BE SPECIFIC.**

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4) Starting date of care:______________________

5) Expected duration of need for these services: ________Week(s) ________Month(s) ________Year(s)

6) Number of hours **PER DAY** that these services are required: RN ________ RPN ________ PSW ________ PB ________

7) Number of days per week: RN ________ RPN ________ PSW ________ PB ________

8) Are the services being requested in addition to those being provided under any Government funded programs ? ☐ Yes ☐ No

If yes, attach a letter outlining what services are being provided. If no, please specify reason. ______________________

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Government Programs

Hours per day____________ Level of Care (RN, PSW)____________ Name of Agency____________

9) Are these services required due to a work related accident? ☐ Yes ☐ No

10) Are these services required due to a motor vehicle accident? ☐ Yes ☐ No

11) During your convalescence at home, will you have to travel to obtain medical care or follow-up? ☐ Yes ☐ No

Please specify the name(s) of the physician(s) you are required to consult :______________________

Please attach a certificate from the physician for each consultation and indicate the hospitalization period or date of day surgery. "Expenses are reimbursed only upon presentation of receipts or paid invoices (e.g. gas, parking, taxi, bus, paratransit)."

12) During your convalescence, will you have to pay for childcare expenses in excess of those usually incurred? ☐ Yes ☐ No

Physician's Signature______________________ ( ) **G.P.** ( ) **Specialist** **Date**______________________

______________________ **Physician's Name (Please Print)**

______________________ **Physician's Phone No.**

By signing this claim form and/or submitting actual receipts, I agree that the information provided on this form is complete and accurate. I understand that the information provided by me to SSQ Insurance about myself and my dependents, will be used by SSQ Insurance for claims adjudication and any other services necessary in the administration of our benefits which may include the exchange of information with other parties to administer this benefit claim.

ALL CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS OF THE DATE OF SERVICE.
THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/PARTICIPANT.

SSQ Life Insurance Company Inc. is committed to keeping your information confidential.