



CLAIM FORM FOR IN HOME SUPPORT SERVICES OF AN RN, RNA, RPN, PERSONAL SUPPORT WORKER

SSQ CERTIFICATE NO.			PROVIDER NO.		
PATIENT NAME		PARTICIPANT NAME		NURSING REGISTRY	
ADDRESS			ADDRESS	CITY	PROVINCE
CITY	PROVINCE	POSTAL CODE	POSTAL CODE	TELEPHONE NO.	

DO YOU HAVE ANY OTHER GROUP INSURANCE COVERAGE THAT MAY INCLUDE THESE SERVICES AS BENEFITS? YES NO

IF YES, INSURANCE COMPANY NAME _____

IF OTHER COVERAGE IS SSQ, INDICATE SSQ CERTIFICATE NUMBER: _____

IS TREATMENT REQUIRED DUE TO A MOTOR VEHICLE ACCIDENT? YES NO DATE OF ACCIDENT: _____

IS TREATMENT REQUIRED DUE TO A WORK RELATED INJURY? YES NO

IS TREATMENT RELATED TO AN OPEN WORKER'S COMPENSATION CLAIM? YES NO DATE OF INJURY: _____

SERVICES WERE PROVIDED BY: RN RNA/RPN PERSONAL SUPPORT WORKER RN/RPN FOOTCARE

DURING THE WEEK COMMENCING SUNDAY _____, _____ TO SATURDAY _____, _____ ACCORDING TO THE FOLLOWING SCHEDULE:

DATE	HOURS WORKED (INDICATE A.M. OR P.M.)				HOURLY RATE	NUMBER OF HOURS	TOTAL CHARGE PER SHIFT	NAME OF INDIVIDUAL PROVIDING CARE	REGISTRATION NUMBER (IF APPLICABLE)
	A.M.	P.M.							
SUNDAY			To						
MONDAY			To						
TUESDAY			To						
WEDNESDAY			To						
THURSDAY			To						
FRIDAY			To						
SATURDAY			To						
SUNDAY			To						
MONDAY			To						
TUESDAY			To						
WEDNESDAY			To						
THURSDAY			To						
FRIDAY			To						
SATURDAY			To						

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.

I CERTIFY THAT THE TREATMENT OUTLINED ABOVE WAS PERFORMED IN THE PATIENT'S HOME AND ALL INFORMATION PROVIDED ON THIS FORM IS ACCURATE	THE CHARGES LISTED ON THIS CLAIM HAVE BEEN PAID IN FULL. PLEASE REIMBURSE THE PARTICIPANT DIRECTLY.	I CERTIFY THAT THE ABOVE TREATMENT WAS RENDERED. PLEASE DIRECT PAYMENT TO THE PROVIDER INDICATED ABOVE.
SIGNATURE OF NURSING REGISTRY OFFICIAL	SIGNATURE OF NURSING REGISTRY OFFICIAL	SIGNATURE OF PATIENT/GUARDIAN

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

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

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