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.		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 about myself and my dependents, will be used by SSQ 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 1-888-400-0023 French 418-651-2588 or Toll Free 1-800-380-2588
Fax Number: 1-855-453-3942

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