



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

Address _____ Height ____ Weight ____

Telephone No. _____ 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.**

- 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. _____

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.