

Dear Plan Member,

To establish the amount of coverage available for nursing care under your group benefit plan, Great-West Life requires you to apply for a pre-care assessment. A pre-care assessment should be applied for before nursing care begins. To apply for a pre-care assessment, the enclosed Nursing Care Health Assessment form must be completed in full and sent to Great-West Life.

If you have not done so already, you will need to apply for your provincial health care plan for home care services. You will also need to advise the provincial home care case coordinator / manager assigned to your case that you are applying to your private health care benefits plan for supplemental nursing benefits and authorize the provincial health care plan to exchange information with Great-West Life.

**Step 1:** The Nursing Care Health Assessment form is divided into four parts. To help avoid a delay in the completion of the pre-care assessment, please be sure to write legibly and complete the entire form as follows:

- Part 1: Patient information - **to be completed by the plan member**. Please note that your Plan Number and Plan I.D. Number must be indicated on the form.
- Part 2: Current medical information - **to be completed by the patient's physician**.
- Part 3: Confirmation of eligibility and coverage for provincial home care - **to be completed by the provincial home care case coordinator / manager**.
- Part 4: Authorization - **to be completed by the plan member and the patient**.

**Step 2:** Once Great-West Life receives the Nursing Care Health Assessment form completed in full, we will review the medical information, contact your provincial home care case coordinator / manager to confirm the services you are receiving, and review your coverage to determine the amount of nursing care coverage available under your group plan.

**Step 3:** Once we have completed the pre-care assessment, we will let you know in writing what amount, if any, of nursing care coverage you are eligible for reimbursement under your group plan.

**If you have any questions about nursing services, please check your employee benefits booklet or call our line toll-free at**

Sincerely,

The Great-West Life Assurance Company

Once complete, return this form to:

**Mail to:** Nursing Specialist, Medical and Dental Services  
Group Health and Dental Benefits  
The Great-West Life Assurance Company  
PO Box 6000 Station Main  
Winnipeg MB R3C 3A5

**IF REQUEST IS URGENT, PLEASE FAX TO:  
204.938.2820 Attention: Nursing Specialist, or  
Email to: MedicalServices@gwl.ca**

As email is not a secure medium, any person with concerns about their medical information being intercepted by an unauthorized party is encouraged to submit their forms by other means.

## INSTRUCTIONS FOR COMPLETION

This form **must be completed in full** to avoid a delay in assessing the claim. Once we have all the required information and have assessed the claim, we will notify the claimant in writing regarding plan coverage and the number of eligible hours.

**Fees for providing medical information are not payable by your plan.**

If you have questions, please refer to your Great-West Life employee benefits booklet or call 1.800.957.9777.

## Part 1 PATIENT INFORMATION to be completed IN FULL by plan member

Plan Number: \_\_\_\_\_ Plan Member I.D. Number: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Last name First name

Patient Address \_\_\_\_\_

Number and street Apt. number City or town Province Postal Code

Date of Birth \_\_\_\_\_

Month Day Year

Language preference:  English  French

Correspondence preference:  Letter mail

Email

Email address: \_\_\_\_\_@\_\_\_\_\_ (illegible writing will default communication to letter mail)

Has a previous application for nursing benefits or health assessment form been submitted?  Yes  No

Other Insurance?  Yes  No

If "Yes", name of insurance company \_\_\_\_\_ Plan number \_\_\_\_\_

**If you have been approved for nursing under another plan/government program aside from provincial home care; please provide us with a copy of this approval.**

## Part 2 CURRENT MEDICAL INFORMATION to be completed by physician (please print clearly)

*(If additional space is required, please attach a separate sheet. Ensure writing is legible)*

Current Diagnosis \_\_\_\_\_

Past Medical History \_\_\_\_\_

Prognosis \_\_\_\_\_

Surgical procedures and dates \_\_\_\_\_

Condition classified as  Acute (< 3 months)  Convalescent (3-6 months)  Chronic (>12 months)

Palliative (end of life)  PPS Score \_\_\_\_\_

Condition classified as  Unstable/unpredictable  Stable/predictable

Level of Care recommended (Coverage will be based on plan design)

RN (Physician must specify details in nursing treatments section)

RPN / LPN (Physician must specify details in nursing treatments section)

HCA / PSW

**Part 2 CURRENT MEDICAL INFORMATION** to be completed by physician (please print clearly) (Con't)

Details of Health Care Aid / Personal Support Worker requirements (non-nursing duties)

\_\_\_\_\_  
\_\_\_\_\_

Details of nursing (RN/RPN/LPN) treatments: dressings, injections, etc. (must be specific to nursing care requested)

**\*Reminder: These duties cannot be those which can be completed by (HCA/PSW). Frequency and length of treatment required.**

1. \_\_\_\_\_  
\_\_\_\_\_  
2. \_\_\_\_\_  
\_\_\_\_\_  
3. \_\_\_\_\_  
\_\_\_\_\_  
4. \_\_\_\_\_  
\_\_\_\_\_

Current medications: route, dose, frequency

1. \_\_\_\_\_ 6. \_\_\_\_\_  
2. \_\_\_\_\_ 7. \_\_\_\_\_  
3. \_\_\_\_\_ 8. \_\_\_\_\_  
4. \_\_\_\_\_ 9. \_\_\_\_\_  
5. \_\_\_\_\_ 10. \_\_\_\_\_

**CHECK OR COMMENT ON ALL THAT APPLY:**

**Vital signs:** BP \_\_\_\_\_ Pulse \_\_\_\_\_ Resp. \_\_\_\_\_ Temp \_\_\_\_\_ O2 sats \_\_\_\_\_

**Pain/discomfort Location 1:** \_\_\_\_\_ **Pain/discomfort Location 2:** \_\_\_\_\_

Frequency \_\_\_\_\_ Frequency \_\_\_\_\_

Duration \_\_\_\_\_ Duration \_\_\_\_\_

Alleviated by \_\_\_\_\_ Alleviated by \_\_\_\_\_

Precipitating factors \_\_\_\_\_ Precipitating factors \_\_\_\_\_

**Integument**

No skin problems  Lesion  Rash  Callous  Bruise  Ulcer  Discharge  Varicosity  Skin breakdown

If yes, explain \_\_\_\_\_

**Oral cavity** Special diet  Yes  No Type: \_\_\_\_\_

No reported concerns  Difficulty chewing  Difficulty swallowing  Dentures:  Upper  Lower

Other \_\_\_\_\_

**Neurological/cognitive levels** Level of consciousness  Alert  Altered

Seizures  Fainting  MMSE Score: \_\_\_\_\_ Date: \_\_\_\_\_  Tremors  Spastic

Cognition/Orientation: Difficulty  Yes  No If yes, please explain: \_\_\_\_\_

Other \_\_\_\_\_

**Respiratory/cardiovascular**

S.O.B.  Rest or activity  Orthopnea Cough:  Non-productive  Productive

Cyanosis  Wheezes  Crackles Oxygen use  Continuous  Intermittent  Rate \_\_\_\_\_

Nebulization  Ventilator  Tracheotomy

Other \_\_\_\_\_

**Cardiovascular** - Chest pain?  Yes  No (If yes, please explain) \_\_\_\_\_

History of:  Hypertension  Hypotension  Dizziness

If yes, explain aggravating factors / remarks: \_\_\_\_\_

**Circulation** Difficulty?  Yes  No (If yes, please explain) \_\_\_\_\_

Edema:  Pitting  Dependent  Right  Left  Bilateral

**Gastrointestinal system**

Bleeding  Ostomy  GI upset  Diarrhea Appetite  Good  Poor

Constipation  Nausea/vomiting  Gastrostomy/enteral tube

Other \_\_\_\_\_

**Vision**

No reported visual loss  Blind  Cataracts  Partially impaired (details) \_\_\_\_\_

**Hearing/ears**

No hearing loss  Hearing device  Deaf  Partially impaired (details) \_\_\_\_\_

**Musculoskeletal**

No reported concerns

Coordination/Balance \_\_\_\_\_  Swollen joints \_\_\_\_\_

Prosthesis R/L \_\_\_\_\_  Limited R.O.M. \_\_\_\_\_

Amputation R/L \_\_\_\_\_  Other \_\_\_\_\_

**Genital/Urinary**

Full control \_\_\_\_\_  Frequency \_\_\_\_\_

Incontinence \_\_\_\_\_  Blood in urine \_\_\_\_\_

Difficulty urinating \_\_\_\_\_  Nocturia \_\_\_\_\_

Indwelling catheter \_\_\_\_\_  Other \_\_\_\_\_

**Activities of daily living**

Adaptive Equipment used at Home:

Cane  Wheelchair  Hospital bed  Eating aids  Standard walker  Wheeled walker  Commode  Toilet aids  Lift

Tub aids  None  Other \_\_\_\_\_

Independent \_\_\_\_\_

Requires assistance with:  Mobility  Feeding  Hygiene  Dressing  Toileting  Other

Assistance provided by: \_\_\_\_\_

Physician name (print) \_\_\_\_\_ Phone number \_\_\_\_\_

Address \_\_\_\_\_  
Number and street City or town Province Postal Code

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Part 3 CONFIRMATION OF PROVINCIAL HOME CARE ENTITLEMENT to be completed by provincial coordinator**

Please be advised that this document will enable the nursing specialist at Great-West Life to expedite your claim in an efficient and accurate manner. Please have your homecare case co-ordinator / manager fill this out.

Patient Name: \_\_\_\_\_

Great-West Life Policy Number: \_\_\_\_\_ Great-West Life ID Number: \_\_\_\_\_

Homecare Manager Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Case Manager: Please provide the current level of care patient is receiving.

**Home Support Workers (\*Circle HCA PSW HOMEMAKERS) - hourly**

Frequency \_\_\_\_\_ Focus of intervention \_\_\_\_\_

Treatment end date \_\_\_\_\_ Max hours reached?  Yes  No

**Nurse Practioner Visits**

Frequency \_\_\_\_\_ Focus of intervention \_\_\_\_\_

Treatment end date \_\_\_\_\_ Max hours reached?  Yes  No

**Nursing (\*Circle RN LPN RPN)**

Home visits only - Frequency \_\_\_\_\_ Focus of intervention \_\_\_\_\_

Shifts in home - Frequency \_\_\_\_\_ Focus of intervention \_\_\_\_\_

Treatment end date \_\_\_\_\_ Max hours reached?  Yes  No

**Palliative Pain & Symptom Management**

Frequency \_\_\_\_\_ Focus of intervention \_\_\_\_\_

Treatment end date \_\_\_\_\_ Max hours reached?  Yes  No

Case Manager Signature \_\_\_\_\_ Date \_\_\_\_\_

**Part 4 AUTHORIZATION to be completed by the plan member and patient**

I certify that the information given on this claim form is true, correct and complete to the best of my knowledge. I certify that all goods and services being claimed have been received by me, my spouse and/or my dependents; and that my spouse and/or dependents are eligible under the terms of my plan.

The submission of fraudulent claims is a criminal offence. Great-West Life takes the submission of fraudulent claims seriously. Suspected fraudulent claims may be reported to your employer or plan sponsor and to the appropriate law enforcement agency.

At Great-West Life, we recognize and respect the importance of privacy. Personal information that we collect will be used for the purposes of assessing your claim and administering the group benefits plan. I authorize Great-West Life, any healthcare or dentalcare provider, my plan administrator, other insurance or reinsurance companies, administrators of government benefits or other benefits programs, other organizations or service providers working with Great-West Life located within or outside Canada, to exchange personal information when necessary for these purposes. I understand that personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

For a copy of our Privacy Guidelines, or if you have questions about our personal information policies and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to [www.greatwestlife.com](http://www.greatwestlife.com).

Plan Member Name \_\_\_\_\_ Signature \_\_\_\_\_

Patient Name \_\_\_\_\_ Signature \_\_\_\_\_

Date \_\_\_\_\_