Hamilton Health Sciences

Preferred Accommodation Authorization Request

Patient Accounts:

Hamilton Health Sciences 905-521-2100 ext 77000

West Lincoln Memorial Hospital Site 905-945-2253 ext 280

Patient Name

Street Address

City | Province | Postal Code

Patient Account Number

... MANDATORY ...

Country

If Patient is under 16 years of age, provide Guarantor information below

INSURANCE INFORMATION	1	2
Policy Holder Name		
Policy Holder Date of Birth		
Relationship to Subscriber		
Employer Name (former if retired)		
Insurance Company		
Policy / Group		
Cert / Identification Numbers		

Preferred Accommodation — **I accept financial responsibility for additional charges for preferred accommodation as indicated below for the period of hospitalization.**

Please Note: It is the patient's responsibility to know their insurance coverage for room accommodation.

Preferred Accommodation Charges

Please Check all that apply

- ☐ Private $ 310.00 each Day
- ☐ Semi-Private $ 275.00 each Day
- ☐ Standard Ward $ _____ each Day

Date: (Must be Indicated) _____

☐ In the event that a private room is not available, I request a semi-private room

IMPORTANT

My initials indicate that it has been explained to me that I will be billed if my insurance company does not pay.

Initials _____

Standard Ward Accommodation (Basic) I accept financial responsibility for the basic Standard Ward accommodation charges for the above patient if the charges are not covered by the Ministry of Health or Workplace Safety & Insurance Board

WSIB Claim Number: _____

Initials _____

Assignment

- I hereby assign to Hamilton Health Sciences, all of the hospitalization benefits provided by my hospital insurance or so much thereof as may serve to satisfy my indebtedness, or that of my dependent to the Hospital, and I hereby authorize Hamilton Health Sciences to release the information for payment of the Hospital claim.
- I authorize my insurance company/ies to assign all payments directly to Hamilton Health Sciences, to cover all charges incurred for this period of hospitalization

Initials _____

Guarantor accepting financial responsibility MUST complete this section.

_____ X _____ _____

Printed Name → Patient (**or** Guarantor, if not the patient) | **(MANDATORY)** Signature → Patient / Guarantor | Phone Number

Guarantor Address: (Street, City, Province/ State, Postal Code/Zip Code, Country): _____

Payment Options: ***Payment is required before discharge, by, cheque, debit transaction or credit card.***

Note – Many supplementary insurance companies will NOT pay for Private or Semi-Private accommodation for WSIB

Comments:

HHS Witness: Printed Name: _____ Signature: _____ Ext: _____