Vancouver CoastalHealth
Promoting wellness. Ensuring care.

Insurance Claim Form > PRIVATE & SEMI PRIVATE Accommodation

ACUTE CARE SITE: _____ **Provider #:** _____

Patient:

Name: _____ Date of Birth: _____

Address: _____

_____

Policy Holder: ☐ *same as patient*

Name: _____ Date of Birth: _____

Address _____

_____ Relationship to patient: _____

Insurance:

Insurance Company _____

Policy Number: _____ Group ID Certificate Number: _____

Dependant Number: _____

I hereby assign **to Vancouver Coastal Health Authority** all of the extended benefits available to me from my extended benefits provider under the applicable health benefits insurance plan to the extent necessary to satisfy my indebtedness, or that of my dependent, to the appropriate Health Authority in respect of the period of hospitalization.

_____ _____
Signature of Policy Holder Date

Finance Office Use Only

Account #: _____ MRN #: _____

Nature of Illness or Injury: _____

Date Admitted: _____ Time: _____

Date Discharged: _____ Time: _____

Dates	# days	Daily Rate	Total
_____	Private _____	X $ 195.00 =	_____
_____	Semi Private _____	X $ 165.00 =	_____
		TOTAL	_____
		Paid on Account	_____
		Balance Due	_____

_____ _____
Authorized Hospital Signature Date

Please remit payment to: PHSA Revenue Services, Accommodation Department,
1795 Willingdon Avenue Burnaby, B.C. V5C 6E3
Any Questions - please contact PHSA RS : (604) 297-8512

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