

Saskatoon Health Region

**INSURANCE INFORMATION  
PREFERRED ACCOMMODATIONS**

*Hospital staff cannot advise you of your insurance coverage.*

Please return to Cashier

|  |                        |                              |                              |                              |                 |
|--|------------------------|------------------------------|------------------------------|------------------------------|-----------------|
| For hospital use only  |                        | <input type="checkbox"/> RUH | <input type="checkbox"/> SPH | <input type="checkbox"/> SCH | Admission Date: |
| <b>Patient Information</b>   |                        |                              | <i>(print clearly)</i>       |                              |                 |
| Last Name  | First Name and Initial |                              | Hospitalization No.          |                              |                 |
| Is your hospital stay due to a work-related injury or illness? <input type="checkbox"/> Yes <input type="checkbox"/> No                          |                        |                              |                              |                              |                 |
| <b>Certificate Holder Information</b> – Fill in Applicable Information   |                        |                              |                              |                              |                 |
| This is information on the <b>person who holds the insurance policy</b> , whether this is the patient or patient's family member.                |                        |                              |                              |                              |                 |
| Last Name  | First Name and Initial |                              | Relationship to Patient      |                              |                 |
| Name of Insurance Company:   |                        |                              |                              |                              |                 |
| Insurance Company's Address ( <i>Street, City, Province, Postal Code</i> )   |                        |                              |                              |                              |                 |
| Policy Number  |                        | <i>and/or</i> Group Number   |                              |                              |                 |
| Plan Name  |                        | <i>or</i> Section Number     |                              | <i>or</i> Division Number    |                 |
| I.D. Number (Example: certificate, employee or Social Insurance number)  |                        |                              |                              |                              |                 |
| Name of Employer   |                        |                              |                              |                              |                 |
| Employer's Address ( <i>Street, City, Province, Postal Code</i> )  |                        |                              |                              |                              |                 |
| <b>Additional Insurance</b>  |                        |                              |                              |                              |                 |
| Are you entitled to benefits from another source (Example: Spouse's Insurance Plan)?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                        |                              |                              |                              |                 |
| If yes: Name of Insurer: _____   |                        |                              | Policy No.: _____            |                              |                 |

Please see reverse for details

**I understand that by providing my insurance information to the Saskatoon Health Region (SHR), I am authorizing SHR to collect directly from my insurance company. If my insurance company covers only part, or none, of this claim, I am responsible for all outstanding Preferred Accommodations charges.**

Policy Holder Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Hospital Staff Initials: \_\_\_\_\_ Original (Finance (Cashiers); Yellow to Patient)

INSURANCE INFORMATION FOR PREFERRED ACCOMMODATIONS

This Form accompanies the “**Agreement to Pay for Preferred Accommodations**” Form.

*If you have Extra Health Insurance, such as an extended health benefits plan through work, or have purchased private insurance, Saskatoon Health Region (SHR) will bill your insurance company directly on your behalf for your Preferred Accommodations room.*

*The insurance information on this form is the information on the person who holds the insurance policy, whether this is the patient or patient's family member. Call the certificate holder's employer or Insurance Provider if you do not have this information or to determine which fields apply to the policy.*

By signing this Form you understand and have authorized SHR to attempt to place you in Preferred Accommodations, and if placed in such accommodations, you are responsible for those charges. If placed in Preferred Accommodations, you may be subsequently moved to another room to accommodate unique medical needs of other patients.

***By selecting “Direct Bill Insurance Provider” on the Agreement to Pay for Preferred Accommodations Form you understand that you are obliged to provide Saskatoon Health Region with the required information to bill your insurance company. If you are unable to provide this information at the time of registration, you must submit it to cashiers before being discharged from the hospital. You also understand that failure to provide complete insurance information will result in your direct and immediate payment to the health region for all Preferred Accommodations charges that are incurred. Although we bill the insurance company directly, the insurance company may direct their payment to the person who holds the insurance policy, in which case that person is then responsible to pay SHR.***

This Form must be completed and submitted to the Cashier before being discharged from the hospital in order for SHR to bill the insurance company.

**IMPORTANT NOTE: Hospital staff cannot advise you of your insurance coverage. Please verify that your insurance coverage is correct. Your insurance company will be billed only once by Accounts Receivable. Rejected insurance claims will become the patient's responsibility.**