COMBINED INSURANCE

Canadian Head Office
P.O. Box 3720 MIP Markham, ON L3R 0X5
Fax: 905 754-4362

COMBINED ASSURANCES

Claim #

RECORD OF HOSPITAL CARE FOR CANCER

TO BE COMPLETED BY THE HEALTH RECORDS

The patient is responsible for securing this form and for charges made for its completion.

Patient's Name _____

Care Unit	Admission Date MM/DD/YYYY	Discharge Date MM/DD/YYYY
Emergency		
Intensive care		
Active care		
Extended or convalescent care		
Other units		

Date of outpatient and/or home administered treatments

SURGERY MM/DD/YYYY	OUTPATIENT CHEMOTHERAPY MM/DD/YYYY	HOME ADMINISTERED CHEMOTHERAPY MM/DD/YYYY	RADIATION MM/DD/YYYY

Date _____ Hospital _____

Signature and stamp of department official

Signature _____ Printed Name _____ Telephone Number _____

AUTHORIZATION TO RELEASE INFORMATION: I authorize Combined Insurance, any healthcare provider, any insurance or reinsurance company, administrators of government benefits or other benefits programs, or any person having knowledge of me or my health, other organizations or service providers working with Combined Inurance, located within or outside Canada, to exchange personal information when relevant for the purposes of investigating, assessing and administering my claim(s).

This authorization shall remain valid for the duration of my claim(s) for benefits or until otherwise revoked by me in writing.

Signature of Claimant _____ Date _____