GREEN SHIELD CANADA

PLEASE USE THIS FOR YOUR NEXT CLAIM SUBMISSION

FOR CLAIMS REQUIRING FORM COMPLETION, REQUEST FORMS FROM CUSTOMER SERVICE:
EHS Services/Medical Equipment/ Supplies/Vision/Hospital/Nursing Home

**CUSTOMER SERVICE CENTRE**

1 888 711-1119

PLEASE INDICATE ON MAILING ENVELOPE
Attn: Drug Dept. P.O. Box 1652, Windsor, ON N9A 7G5
Attn: Professional Services, P.O. Box 1699, Windsor, ON N9A 7G6
Attn: Medical Items, P.O. Box 1623, Windsor, ON N9A 7B3
Attn: Out-of-Country Dept. P.O. Box 1606, Windsor, ON N9A 6W1
Attn: Vision/Hospital Dept. P.O. Box 1615, Windsor, ON N9A 7J3
Attn: Dental Dept. P.O. Box 1608, Windsor, ON N9A 7G1

# CLAIM SUBMISSION FORM
## Mandatory Declaration

Do you have any other group insurance coverage that may include the claim as a benefit?

Yes ☐ No ☐

If yes, please indicate name of other insuring agency

_____

If other coverage is Green Shield, indicate Green Shield Identification No.: _____

Submit Copies of Other Carrier's Statement along with copies of corresponding receipts.

Are any of the enclosed claims due to:

1. A work related injury Yes ☐ No ☐
2. A Motor Vehicle Accident Yes ☐ No ☐

If "Yes" please indicate the date of the accident (loss)

_____

**PLEASE INCLUDE ORIGINAL PAID RECEIPTS**

_____
Subscriber signature

Subscriber Surname including alternate surname if applicable

Company Name

Green Shield Identification Number

Patient's First Name

Birth Date: Year / Month / Day

Only include names of patients with receipts attached.

Street Address _____

City _____ Province _____ Country _____

Postal Code _____ Telephone ___ - ___ - ____

**By signing this claim form and/or submitting actual receipts, I agree that the information provided on this form is complete and accurate. I understand that the information provided by me to Green Shield Canada about myself and my dependants, will be used by Green Shield Canada for claims adjudication and any other services necessary in the administration of our benefits which may include the exchange of information with other parties to administer this benefit claim.**

**I am authorized by my spouse and/or dependants to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.**

**cut along dotted line**

## GREEN SHIELD CANADA CLAIMS SUBMISSION INSTRUCTIONS

**Please call our Customer Service Centre at 1-888-711-1119 if you require any assistance in completing this form.**
**Please ensure that you always provide your Green Shield Identification Number in full, including suffix (ie. 00, 01, etc.)**

| FOR BENEFIT TYPE: | ALWAYS ENCLOSE THE FOLLOWING ITEMS WITH THE ABOVE CLAIM FORM: |
|---|---|
| Audio (Hearing Aids) | Itemized receipts showing<br>• patient name<br>• services & dates<br>• audiologist name & address<br>• breakdown of charges (ie. Acquisition cost, fee, mold) |
| Prescription Drugs | All itemized Prescription drug receipts from your pharmacist<br>*Please note cash register receipts or credit card receipts alone are unacceptable |
| Professional Services (Physiotherapy, Chiropractor, etc.) | Itemized receipts showing<br>• patient name<br>• individual date & nature of treatment<br>• charge for each service<br>*First claim for Massage therapy must include Physician's written approval |
| Durable Medical Equipment (including prosthetics or orthotics) | Itemized receipts showing<br>• patient name<br>• a detailed description of the equipment<br>• name & address of supplier<br>• date & charge for each service<br>*Some medical equipment may require Physician's approval - call Green Shield for details |
| Hospital Accommodation | Itemized receipts showing<br>• patient name<br>• number of days in semi-private/private accommodation<br>• rate charged per day<br>• admission & discharge dates |
| Vision Care | Itemized receipts showing<br>• patient name<br>• copy of vision prescription<br>• a breakdown of charges for lenses & frames<br>• date glasses were picked up |
| Extended Health - General | Itemized receipts showing<br>• patient name<br>• a detailed description of services or supplies<br>• provider's name & address<br>• date & charge for each service<br>*Medical referral may be required for certain types of service or supplies |
| Out of Province/Country | Call Customer Service at 1-888-711-1119 for detailed claims submission instructions |
| Private Duty Nursing | Call Customer Service at 1-888-711-1119 for detailed claims submission instructions<br>*Pre-approval is required for all nursing claims - call Customer Service for details |