GREEN SHIELD CANADA

GENERAL CLAIM SUBMISSION FORM

SECTION 1 – PLAN MEMBER INFORMATION

GREEN SHIELD CANADA ID NUMBER		COMPANY NAME
SURNAME	FIRST NAME	PHONE NUMBER
ADDRESS		EMAIL ADDRESS
CITY	PROVINCE	POSTAL CODE

SECTION 2 - MANDATORY DECLARATION

Do you have any other group insurance coverage that may include these services as benefits? YES ☐ NO ☐

If Yes, please provide Insurance company's name ____________________

If other coverage is Green Shield Canada, indicate Green Shield Canada ID number: ____________________

Is treatment due to a motor vehicle accident? YES ☐ NO ☐ If yes, Date of Accident (YY/MM/DD) ____________________

Is treatment required due to a work related injury? YES ☐ NO ☐ If yes, Date of Injury (YY/MM/DD) ____________________

If yes, WSIB Case # ____________________

SECTION 3 – CLAIM DETAILS

PATIENT'S NAME (Only include names of patients with receipts attached)	DEP NO.	DATE OF BIRTH			PROFESSIONAL/ SUPPLIER'S NAME and Provider Number (if available)	DATE OF CLAIM			TYPE OF EXPENSE	TOTAL AMOUNT CHARGED PER VISIT/ ITEM
		YR	MO	DAY		YR	MO	DAY		
									TOTAL CLAIMED	

FOR PRESCRIPTION DRUG CLAIMS ONLY:

TO FACILITATE CLAIMS PROCESSING:

- **Please note: Cash register receipts, credit card receipts and/or debit slips alone are insufficient. Official pharmacy receipts are required.**
- **Original receipts must contain patient's name, date of service, Rx number, drug name, quantity dispensed and Drug Identification Number (DIN)**
- **If injectable, please contact Green Shield Canada for specific claim requirements.**

If claim is from OUT OF COUNTRY, please provide:

Name of Country Visited ____________________ **Currency Used** ____________________ **Name of Drug** ____________________

SECTION 4 - AUTHORIZATION

____________________ ____________________

SIGNATURE OF PLAN MEMBER **DATE**

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 dependents, 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 dependents to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.

SECTION 5 – MAILING INSTRUCTIONS (See reverse for claim submission instructions)

PLEASE ATTACH ALL ORIGINAL CORRESPONDENCE and retain copies for your files as original receipts will not be returned.
ALL CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS OF THE DATE OF SERVICE
PLEASE INDICATE ON MAILING ENVELOPE:

PARAMEDICAL SERVICES
P.O. BOX 1699
WINDSOR, ON
N9A 7G6

MEDICAL ITEMS
P.O. BOX 1623
WINDSOR, ON
N9A 7B3

VISION & ACCOMMODATION
P.O. BOX 1615
WINDSOR, ON
N9A 7J3

DRUG
P.O. BOX 1652
WINDSOR, ON
N9A 7G5

OTHER CLAIMS
P.O. BOX 1606
WINDSOR, ON
N9A 6W1

GREEN SHIELD CANADA
CUSTOMER SERVICE CENTRE 1-888-711-1119 or (519) 739-1133
greenshield.ca

GREEN SHIELD CANADA CLAIM 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 Canada ID 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 ● patient name ● services & dates ● audiologist name & address ● breakdown of charges (i.e. Acquisition cost, fee, mold)
Prescription Drugs	All itemized prescription drug receipts from your pharmacist *Please note cash register receipts, credit card receipts and/or debit slips alone are insufficient. Official pharmacy receipts are required. Please contact your pharmacy for a duplicate copy.
Professional Services (physiotherapy, chiropractor, massage therapy, etc.)	Itemized receipts showing ● patient name ● individual date & nature of treatment ● charge for each service *Some professional services may require a medical referral/physician prescription. Please call Customer Service at 1-888-711-1119 for details.
Durable Medical Equipment (including prosthetics or orthotics)	Itemized receipts showing ● patient name ● a detailed description of the equipment ● name & address of supplier ● date & charge for each service *Some medical equipment may require a medical referral/physician prescription. Please call Customer Service at 1-888-711-1119for details.
Hospital Accommodation	Itemized receipts showing ● patient name ● number of days in semi-private/private accommodation ● rate charged per day ● admission & discharge dates
Vision Care	Itemized receipts showing ● patient name ● copy of vision prescription ● a breakdown of charges for lenses & frames ● date glasses were picked up
Extended Health – General	Itemized receipts showing ● patient name ● a detailed description of services or supplies ● provider's name & address ● date & charge for each service *Certain types of service or supplies may require a medical referral/physician prescription. Please call Customer Service at 1-888-711-1119 for details.
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. *Pre-approval is required for all nursing claims - call Customer Service for details.