NO STAPLES PLEASE, PAPER CLIPS ONLY



GENERAL CLAIM SUBMISSION FORM

each person must complete own claim form

Did you know that most claims can be submitted online, and you could receive your claim payment faster with direct deposit?

Go to www.greenshield.ca for more details

SECTION 1 - PLAN MEMBER INFORMATION					
PLAN MEMBER ID	EMAIL A	EMAIL ADDRESS			
SURNAME FIRST NAME	PHONE	PHONE NUMBER			
ADDRESS	COMPA	NY NAME			
CITY	PROVIN	CE		POSTAL CODE	
SECTION 2 - MANDATORY DECLARATION					
Do you have any other group insurance coverage that may include these services as benefits?					
If we are your secondary carrier, please attach copies of your receipt and your Explanation of Benefit statement from your primary carrier. If other coverage is with Green Shield Canada Insurance, indicate other Plan Member ID:					
Do you want to coordinate this claim with your other Green Shield Canada Insurance Coverage?					
Is treatment due to a motor vehicle accident? YES NO If yes, include date of accident Include which expenses are MVA related					
Is treatment required due to a work related injury? YES NO If yes, include date of injury WCB Case # Include which expenses are a result of the work related incident					
Do you want to coordinate these claims with your Health Care Spending Account (if applicable)? YES NO If yes, include which claims are to be coordinated with HCSA					
PATIENT'S NAME		DEPENDENT NO. DATE OF BIRTH			
	(-00, -01	, -02)	YR	MO	DAY
SECTION 3 - AUTHORIZATION AND CONSENT					
information is a priority. In order to provide you with the services for which we have been engaged, we need you to understand, and consent to, a few things. We may collect/receive from you or other parties and use, share, disclose and process your personal information and, if applicable, that of your spouse, children and other dependents (collectively, "you" or "your"), which may include name, age, claims history, income, email address, service providers that may have been used and banking information. We may do this for various purposes related to the administration of your benefits plan and to provide you other products and services, including but not limited to: benefits coordination with other carriers; administration and adjudication of claims; auditing, investigating, and taking steps connected to the prevention or suppression of suspected or proven improper or fraudulent claims; identity checks; billing and collection of premiums; medical underwriting; communication with third parties to confirm the accuracy of claims, provide contracted services, or for health management purposes or programs; collecting information about services that are provided, analyzing data, including information on how you use our products and services when informed decisions and improve the products and services were not expressed in a machine provider, and services were not expressed in a service with a service and services were or disclose your personal information with others outside of GreenShield, including, but not limited to: your employer, sponsor(s) of your benefit plan, and insurance advisors, if your benefits are provided through your employer; sgroup benefits plan; benefits providers (e.g., pharmacists), massage therapists); professional regulatory bodies (e.g., College of Pharmacists); government agencies; applicable law enforcement bodies (local, provincial and federal); industry drug pooling entities (e.g. Canadian Drug Insurance Pooling Corporation); GreenShield's third party service providers who assist us in a					
Name Signatul	re		Date		

SECTION 4 - MAILING INSTRUCTIONS

ALL CLAIMS MUST BE RECEIVED WITHIN 12 MONTHS OF THE DATE OF SERVICE (unless otherwise stated in your benefit plan documentation). PLEASE ATTACH ALL ORIGINAL DOCUMENTATION and retain copies for your files as original receipts will not be returned.

Send your claim to the corresponding address below (be sure to indicate the full address on the envelope):

PROFESSIONAL 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 NOA 7 13 DRUG P.O. BOX 1652 WINDSOR, ON N9A 7G5 DENTAL P.O. BOX 1608 WINDSOR, ON N9A 7G1

To avoid additional postage costs, please submit multiple claims in one envelope to any of the addresses listed above.

GREEN SHIELD CANADA INSURANCE CLAIM SUBMISSION INSTRUCTIONS Please call our Customer Service Centre at 1-888-711-1119 or (519) 739-1133 if you require any assistance in completing this form. Please ensure that you always provide your Plan Member ID in full, including suffix (ie. 00, 01, etc.).			
FOR BENEFIT TYPE (where applicable):	ALWAYS ENCLOSE THE FOLLOWING ITEMS WITH THE ABOVE CLAIM FORM: The listing below may include benefits not covered by your plan		
Audio (Hearing Aids)	Itemized receipts showing patient name, services & dates, audiologist name & address, prescriber / dispenser information and audiogram.		
Professional Services (physiotherapy, chiropractor, massage therapy, etc.)	Itemized receipts showing patient name, individual date & nature of treatment, and the charge for each service. Some professional services may require a medical referral/physician prescription.		
Durable Medical Equipment (including prosthetics)	Itemized receipts showing patient name, a detailed description of the equipment, name & address of supplier, and date & charge for each service. Some medical equipment may require a medical referral/physician prescription and/or prior authorization.		
Custom Foot Orthotics	Itemized receipts showing patient name, name & address of supplier, charge for service, casting technique, and date orthotics were received. A prescription with diagnosis as well as Biomechanical Exam or Gait Analysis and a copy of the lab invoice is required. Above items are required unless otherwise specified by your plan sponsor.		
Hospital Accommodation	Itemized receipts showing patient name, number of days in semi-private / private accommodation, rate charged per day, and admission & discharge dates		
Vision Care	Itemized receipts showing patient name, copy of vision prescription, a breakdown of charges for lenses & frames, and date eyewear received or paid in full.		
Extended Health - General	Itemized receipts showing patient name, a detailed description of services or supplies, provider's name & address, and date & charge for each service. Certain types of service or supplies may require a medical referral/physician prescription and/or prior authorization.		
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.		
Medical Cannabis	Receipt/Shipping confirmation showing patient name, date of order, breakdown of charges (ie ingredient cost, taxes, shipping charges, discounts applied), name of prescriber, authorized grams per day, and medical document expiry date.		
Prescription Drugs	Itemized prescription drug receipts from your pharmacist. Receipts must contain patient's name, date of service, Rx number, drug name, quantity dispensed and Drug Identification Number (DIN). 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. If injectable, please provide breakdown of quantity dispensed, drug cost and administration fees.		
	If claim is from OUT OF COUNTRY, please also provide:		
	Name of Country Visited		
	Currency Used Name of Drug		
	Name of Drug		