



GENERAL CLAIM SUBMISSION FORM

SECTION 1 - PLAN MEMBER INFORMATION

GREEN SHIELD CANADA ID NUMBER		EMAIL ADDRESS	
SURNAME	FIRST NAME	PHONE NUMBER	
ADDRESS		COMPANY NAME	
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 with Green Shield Canada, indicate other Green Shield Canada ID number: _____

Do you want to coordinate this claim with your other Green Shield Canada Coverage? YES NO
Do you want to coordinate this claim with your Health Care Spending Account (if applicable)? YES NO

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 / WCB Case # _____

SECTION 3 - CLAIM DETAILS

PATIENT'S NAME (Only include names of patients with receipts attached)	DEPENDENT NO. (-00, -01, -02)	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 provide breakdown of quantity dispensed, drug cost and administration fees.

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 _____

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.

By signing this claim form and/or submitting actual receipts, I agree that the information provided 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 further authorize Green Shield Canada to obtain and exchange information with other parties, such as health practitioners or insurers, in order to confirm the accuracy of the submitted claim(s) information. In the event of suspected fraudulent activity pertaining to claims submitted on behalf of myself and/or my dependents, I acknowledge and agree to the disclosure of this information to relevant parties, such as the Plan Sponsor, regulatory and law enforcement agencies.

SECTION 5 - MAILING INSTRUCTIONS (See reverse for claim submission 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
N9A 7J3

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

OTHER CLAIMS
P.O. BOX 1605
WINDSOR, ON
N9A 6W1

To avoid additional postage costs, please submit multiple claims in one envelope to any of the addresses listed above. When in doubt, choose the "OTHER CLAIMS" address.

CUSTOMER SERVICE CENTRE 1-888-711-1119 or (519) 739-1133

greenshield.ca