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 Green Shield Canada, indicate Green Shield Canada ID number: ______

Do you want this claim coordinated? YES ☐ NO ☐

Is treatment due to a motor vehicle accident? YES ☐ NO ☐ If yes, Date of Injury (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)	DEP NO.	DATE OF BIRTH YR	MO	DAY	PROFESSIONAL/ SUPPLIER'S NAME and Provider Number (if available)	DATE OF CLAIM YR	MO	DAY	TYPE OF EXPENSE	TOTAL AMOUNT CHARGED PER VISIT/ ITEM
									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 ______

By signing this claim form and 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)

ALL CLAIMS MUST BE SUBMITTED 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	MEDICAL ITEMS	VISION & ACCOMMODATION	DRUG	OTHER CLAIMS
P.O. BOX 1699	P.O. BOX 1623	P.O. BOX 1615	P.O. BOX 1652	P.O. BOX 1606
WINDSOR, ON	WINDSOR, ON	WINDSOR, ON	WINDSOR, ON	WINDSOR, ON
N9A 7G6	N9A 7B3	N9A 7J3	N9A 7G5	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**

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