CLAIM FORM FOR MEDICAL DEVICES

PLEASE USE ONE FORM PER PRACTITIONER, PER PATIENT. PLEASE DO NOT USE THIS FORM FOR: CUSTOM-MADE FOOT ORTHOTICS OR CUSTOM FOOTWEAR

Additional supplies of this form are available at www.greenshield.ca.

PROVIDER			PATIENT		
GREEN SHIELD PROVIDER NO.	PROVIDER PHONE NO. ( )		GREEN SHIELD I.D. #	DEP #	COMPANY NAME
PROVIDER NAME			SURNAME FIRST NAME		BIRTH DATE ____/____/____ YY MM DD
ADDRESS			ADDRESS		
CITY	PROVINCE	POSTAL CODE	CITY	PROVINCE ON	POSTAL CODE

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.

	MEDICAL DEVICES PROVIDED	YY	MM	DD	TAX INC.	CHARGES $
1.						
2.						
3.						
4.						
5.						
6.						
	TOTAL					

A physician's prescription or authorization may be required to complete the processing of this claim.

DO YOU HAVE ANY OTHER GROUP INSURANCE COVERAGE THAT MAY INCLUDE THESE SERVICES AS BENEFITS? YES ☐ NO ☐

IF YES, INSURANCE COMPANY NAME _____

IF OTHER COVERAGE IS GREEN SHIELD, INDICATE GREEN SHIELD NUMBER _____

IS TREATMENT REQUIRED DUE TO A MOTOR VEHICLE ACCIDENT? YES ☐ NO ☐ DATE OF ACCIDENT _____

IS TREATMENT REQUIRED DUE TO A WORK RELATED INJURY? YES ☐ NO ☐

IS TREATMENT RELATED TO AN OPEN WORKER'S COMPENSATION CLAIM? YES ☐ NO ☐ DATE OF INJURY _____

I CERTIFY THAT THE TREATMENT DESCRIBED ABOVE WAS RENDERED BY ME AND ALL INFORMATION PROVIDED ON THIS FORM IS ACCURATE.

SIGNATURE OF PROVIDER _____ REGISTRATION NO., CREDENTIALS & ASSOCIATION _____

I CERTIFY THAT THE ABOVE MEDICAL DEVICES WERE RECEIVED.

SIGNATURE OF PATIENT _____

THE CHARGES LISTED ON THIS CLAIM HAVE BEEN PAID IN FULL BY THE PLAN MEMBER. PLEASE REIMBURSE PLAN MEMBER DIRECTLY.

SIGNATURE OF PROVIDER _____

I CERTIFY THAT THE ABOVE LISTED MEDICAL DEVICES WERE RECEIVED AND HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE PROVIDER.

SIGNATURE OF PATIENT _____

THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/PLAN MEMBER.
ALL CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS OF THE DATE OF SERVICE (unless otherwise stated in you benefit plan documentation).

PLEASE ATTACH ALL ORIGINAL PAID RECEIPTS, PRESCRIPTIONS AND AUTHORIZATION FORMS.
Please retain copies for your files as original receipts will not be returned.

GREEN SHIELD CANADA
P.O. BOX 1699, WINDSOR, ONTARIO N9A 7G6
ATTENTION: EHS DEPARTMENT
CUSTOMER SERVICE CENTRE 1-888-711-1119 or (519) 739-1133