NO STAPLES PLEASE, PAPER CLIPS ONLY

GreenShield™ Insurance

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 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 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 ? YES ☐ NO ☐

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. (-00, -01, -02)	DATE OF BIRTH YR	MO	DAY

SECTION 3 - AUTHORIZATION AND CONSENT

At Green Shield Canada Insurance ("**GreenShield**," "**we**," "**us**" or "**our**"), respecting and protecting the privacy and confidentiality of your personal 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 other service providers, 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, to help us make informed decisions and improve the products and services we offer; determining if there are other products and services that you might be interested in, and sending you details about them; compliance with applicable laws and regulations; and such other activities that a reasonable person would consider associated with the administration of your benefit plan. In carrying-out these purposes, we may collect, receive, share 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's group 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 administering your benefits plan and providing you with other related products and services and such other third parties as may be appropriate or reasonably necessary in carrying out the purposes set out above. Although sharing of personal information is inherently risky, we implement commercially-acceptable procedures to secure and protect your personal information using appropriate technological, physical and organizational measures designed to protect personal information. In the event of an unauthorized release by us of your personal information, we will notify you in accordance with applicable privacy laws. More information about our privacy practices is available in our Privacy Policy at www.greenshield.ca, which is a necessary and integral part of this privacy consent. We may from time to time revise our Privacy Policy to reflect changes in, for example, legislation or regulation, or as we introduce new features, products or services. The most current version of the policy will govern how we process your personal data and will always be available on www.greenshield.ca. You can contact our Privacy Officer at privacy.office@greenshield.ca if you have a question or complaint.

By signing below, you are providing your consent to GreenShield's collection, use and disclosure of your personal information as explained above, and you are acknowledging that you are authorized by your spouse, children and other dependents (if applicable) to disclose and receive their personal information, and to provide this privacy consent on their behalf. You agree that a photocopy, facsimile or electronic version of this consent will be as valid as the original. You can withdraw your consent at any time by providing notice in writing to GreenShield at privacy.office@greenshield.ca, but, if you do so, GreenShield will no longer be able to administer your benefits plan and process your claims.

Name	Signature	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	MEDICAL ITEMS	VISION & ACCOMMODATION	DRUG	DENTAL
P.O. BOX 1699	P.O. BOX 1623	P.O. BOX 1615	P.O. BOX 1652	P.O. BOX 1608
WINDSOR, ON	WINDSOR, ON	WINDSOR, ON	WINDSOR, ON	WINDSOR, ON
N9A 7G6	N9A 7B3	N9A 7J3	N9A 7G5	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** _____