HEALTH CARE CLAIM FORM

Section 1 Plan Member Information

Please print clearly

Name of Plan Member	Identification No.

Address

Home Telephone	Work Telephone	Email

Section 2 Patient Information (Only include names of patients with receipts attached)

First Name	Last Name	Dependent No.	Date of Birth (yyyy/mm/dd)

Section 3 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 Identification No. _____

Do you want to co-ordinate this claim with your other Green Shield Canada coverage? ❑ Yes ❑ No

Do you want to co-ordinate 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 _____ (yyyy/mm/dd)

Is treatment required due to a work-related injury? ❑ Yes ❑ No If yes, date of injury _____ (yyyy/mm/dd)

If yes, WCB/WSIB Case No. _____

Section 4 Claim Details

Patient's First Name	Dependent No.	Name of Professional/Supplier and Provider No. (if available)	Date of Claim (yyyy/mm/dd)	Type of Expense	Total Amount Charged Per Visit/Item
					$
					$
					$
					$
					$

Section 5 Authorization

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.

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.

Please sign here

Plan Member Signature _____ Date (yyyy/mm/dd) _____

Section 6 Mailing Instructions

Mail this form and enclosures to: Green Shield Canada, at the appropriate department address:

Professional Services	**Medical Items**	**Other Claims**	**Drug Dept.**	**Vision and Accommodation**
P.O. Box 1699	P.O. Box 1623	P.O. Box 1606	P.O. Box 1652	P.O. Box 1615
Windsor, ON	Windsor, ON	Windsor, ON	Windsor, ON	Windsor, ON
N9A 7G6	N9A 7B3	N9A 6W1	N9A 7G5	N9A 7J3

gsc green shield canada

CLAIMS SERVICE CENTRE 1-888-711-1119

For claims requiring pre-authorization or specific claim forms, please request from our Claims Service Centre.

Please attach all original paid receipts, prescription and authorized forms.

Please retain copies for your files as original receipts will not be returned.

The intentional falsification, misrepresentation or omission of information on or relating to this claim constitutes fraud.

Victor Insurance Managers Inc.

www.victorinsurance.ca

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