TotalGUARD

For claims requiring pre-authorization or specific claim forms, please request from our **CUSTOMER SERVICE CENTRE 1-888-711-1119**

EHS CLAIM SUBMISSION FORM (required for timely processing of claims)

A. SUBSCRIBER INFORMATION

Subscriber Surname _____ **Green Shield I.D. #** _____

Street Address _____ City _____ Province _____ Postal Code _____

Home Telephone # (_____)_____ Work Telephone # (_____)_____ E-mail Address _____ Name of Employer _____

B. PATIENT INFORMATION (Only include names of patients with receipts attached.)

First Name	Last Name	Dependant #	Date of Birth _____/_____/_____ yr mm dd
			Date of Birth _____/_____/_____ yr mm dd
			Date of Birth _____/_____/_____ yr mm dd

C. MANDATORY DECLARATION

1. Are any of the expenses being claimed covered by another group insurance plan? ☐ No ☐ Yes. If yes, complete the following information about **the person who is the MEMBER under the other plan: (If claiming coordination of benefits, please provide alternate carrier's explanation of benefits)**

   Other Member's Name _____

   If other coverage is Green Shield, indicate Green Shield Identification No.: _____

2. Are any of the expenses being claimed due to: a) A work related injury? ☐ No ☐ Yes If yes, date of injury _____

   WSIB Claim No. _____ (check yes only if claimed with WSIB)

   b) A motor vehicle accident? ☐ No ☐ Yes If yes, date of accident_____

   Name of Auto Insurance Co _____ Claim No _____

D. CLAIMS (All claims must be submitted within 12 months of the date of service.)

Patient's First Name	Dep #	Professional's/ Supplier's Name & Provider # (if available)	Date of Claim (yr/mm/dd)	Type of Expense	Total Amount Charged Per Visit/Item

E. 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 dependants, 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 dependants to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.

Subscriber's Signature X _____ Date _____

F. MAILING INSTRUCTIONS

Please indicate on mailing envelope: Attention:

Professional Services	**Medical Items**	**Out-of Country Dept. & HCSA**	**Vision & Accommodation**
P.O. Box 1699	P.O. Box 1623	P.O. Box 1606	P.O. Box 1615
Windsor, ON	Windsor, ON	Windsor, ON	Windsor, ON
N9A 7G6	N9A 7B3	N9A 6W1	N9A 7J3

PLEASE ATTACH ALL ORIGINAL PAID RECEIPTS, PRESCRIPTIONS AND AUTHORIZATION 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.