

TotalGUARD

PLEASE USE THIS FOR YOUR NEXT CLAIM SUBMISSION
 PLEASE INDICATE ON MAILING ENVELOPE
 Attn: Drug Dept. P.O. Box 1652, Windsor, ON N9A 7G5
 Attn: Professional Services, P.O. Box 1699, Windsor, ON N9A 7G6
 Attn: Medical Items, P.O. Box 1623, Windsor, ON N9A 7B3
 Attn: Out-of-Country Dept. P.O. Box 1606, Windsor, ON N9A 6W1
 Attn: Vision/Hospital Dept. P.O. Box 1615, Windsor, ON N9A 7J3
 Attn: Dental Dept. P.O. Box 1608, Windsor, ON N9A 7G1

FOR CLAIMS REQUIRING FORM
 COMPLETION, REQUEST FORMS FROM
 CUSTOMER SERVICE:
 EHS Services/Medical Equipment/
 Supplies/Vision/Hospital/Nursing Home

CUSTOMER SERVICE CENTRE

1 888 711-1119

**CLAIM SUBMISSION FORM
 Mandatory Declaration**

Do you have any other group insurance coverage that may include the claim as a benefit?

Yes No

If yes, please indicate name of other insuring agency

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

Submit Copies of Other Carrier's Statement along with copies of corresponding receipts.

Are any of the enclosed claims due to:

1. A work related injury Yes No

2. A Motor Vehicle Accident Yes No

If "Yes" please indicate the date of the accident (loss)

Subscriber Surname including alternate surname if applicable _____ Company Name _____

Green Shield Identification Number _____ Patient's First Name _____ Birth Date _____
 Year _____ Month _____ Day _____

Only include names of patients with receipts attached.

Street Address _____

City _____ Province _____ Country _____

Postal Code _____ Telephone _____ - _____ - _____

PLEASE INCLUDE ORIGINAL PAID RECEIPTS

Subscriber signature _____

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.



cut along dotted line

GREEN SHIELD CANADA CLAIMS SUBMISSION INSTRUCTIONS

Please call our Customer Service Centre at 1-888-711-1119 if you require any assistance in completing this form.

Please ensure that you always provide your Green Shield Identification Number in full, including suffix (ie. 00, 01, etc.)

FOR BENEFIT TYPE:	ALWAYS ENCLOSE THE FOLLOWING ITEMS WITH THE ABOVE CLAIM FORM:
Audio (Hearing Aids)	Itemized receipts showing <ul style="list-style-type: none"> patient name services & dates audiologist name & address breakdown of charges (ie. Acquisition cost, fee, mold)
Prescription Drugs	All itemized Prescription drug receipts from your pharmacist *Please note cash register receipts or credit card receipts alone are unacceptable
Professional Services (Physiotherapy, Chiropractor, etc.)	Itemized receipts showing <ul style="list-style-type: none"> patient name individual date & nature of treatment charge for each service *First claim for Massage therapy must include Physician's written approval
Durable Medical Equipment (including prosthetics or orthotics)	Itemized receipts showing <ul style="list-style-type: none"> patient name a detailed description of the equipment name & address of supplier date & charge for each service *Some medical equipment may require Physician's approval - call Green Shield for details
Hospital Accommodation	Itemized receipts showing <ul style="list-style-type: none"> patient name number of days in semi-private/private accommodation rate charged per day admission & discharge dates
Vision Care	Itemized receipts showing <ul style="list-style-type: none"> patient name copy of vision prescription a breakdown of charges for lenses & frames date glasses were picked up
Extended Health - General	Itemized receipts showing <ul style="list-style-type: none"> patient name a detailed description of services or supplies provider's name & address date & charge for each service *Medical referral may be required for certain types of service or supplies
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