

TotalGUARD VISION CARE CLAIM FORM

PROVIDER IDENTIFICATION				Date of Pick Up	
<input style="width: 100px; height: 20px;" type="text"/> Provider No.		<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/>	<input style="width: 30px; height: 20px;" type="text"/>	P A T I E N T
Name		Year	Month	Day	
Address		Optometrist <input type="checkbox"/> Optician <input type="checkbox"/>			
City/Town	Prov.	Postal Code			
Signature		Telephone No. ()		Employer's Name:	
				Telephone No. ()	

Green Shield No.	
Surname	Given Name
Address	
Apt.	
City	Postal Code
Prov.	
Relationship to Subscriber	Date of Birth ____/____/____ Yr Mo Day
Employer's Name:	Telephone No. ()

Do you have other Vision Care Coverage? Yes No

If Yes, Please Complete Policy No. _____
Name of Insurer or Plan _____

If Yes, either a copy of the payment statement or denial letter from the primary carrier must be attached.

Is this a W.S.I.B. claim? Yes No

Subscriber's
Date of Birth Yr Mo Day

Spouse's
Date of Birth Yr Mo Day

Must Be Completed By Supplier in All Cases

New Prescription Yes Lenses Only Yes
 Safety Glasses Yes Post-Cataract Claim Yes
 If yes for post-cataract, does patient have a lens implant? Yes No

Frame and Manufacturer

Eye Size

Plastic Heat Hardened Chemically Hardened

BREAKDOWN OF EXTRA CHARGES: (EG. OVERSIZE, PHOTOGREY, CASE, ETC.)

MISCELLANEOUS	AMOUNT
1. _____	\$ _____
2. _____	\$ _____
3. _____	\$ _____
TOTAL \$ _____	

TRANSFER ITEMS TO MISC. BELOW

Prescription Details

Sphere	Cylinder	Axis	Prism	Tint
R				(Colour & No.) 1 2
L				
Add Bifocal	Type of Bifocal	Add Trifocal	Type of Trifocal	
R		R		
L		L		

Actual Charges	Green Shield Only
Frame	
Eyeglass Lenses	
Fee	
Contact Lenses	
Misc. 1	
Misc. 2	
Misc. 3	
Eye Exam	
Total	
Patient Paid	
Balance to be Paid to Supplier	

CONTACT LENSES:

A) CAN VISUAL ACUITY BE RESTORED TO AT LEAST 20/70 IN THE BETTER EYE WITH CONVENTIONAL EYE GLASSES? Yes No

B) CAN VISUAL ACUITY BE RESTORED TO AT LEAST 20/40 IN THE BETTER EYE WITH CONVENTIONAL EYE GLASSES? Yes No

C) ARE THEY MEDICALLY NECESSARY DUE TO KERATOCONUS, IRREGULAR ASTIGMATISM OR IRREGULAR CORNEAL CURVATURE? Yes No

(THERE IS NO NEED TO ATTACH A RECEIPT IF THIS FORM HAS BEEN COMPLETED AND IF THIS AREA HAS BEEN SIGNED.)

THE CHARGES LISTED ON THIS CLAIM HAVE BEEN PAID IN FULL BY THE SUBSCRIBER. PLEASE PAY SUBSCRIBER FOR ELIGIBLE CHARGES.

SIGNATURE OF SUPPLIER _____

I UNDERSTAND THAT THE CHARGES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY AGREEMENT BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY SUPPLIER FOR THE COST OF THOSE SERVICES. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS FORM.

SIGNATURE OF PATIENT OR PARENT/GUARDIAN

(ONLY COMPLETE THIS SECTION ON THE DATE OF PICKUP, AND ONLY IF THIS FORM IS COMPLETED.) I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE ABOVE NAMED SUPPLIER AND AUTHORIZE PAYMENT DIRECTLY TO THE SUPPLIER.

SIGNATURE OF SUBSCRIBER

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.