Green Shield CANADA

*Where quality is more than a claim*

**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)

_____

**PLEASE INCLUDE ORIGINAL PAID RECEIPTS**

Subscriber Surname including alternate surname if applicable

_____

Company Name

_____

Green Shield Identification Number

_____ - ☐☐ - ☐☐ - ☐☐ - ☐☐

Only include names of patients with receipts attached.

Patient's First Name

_____

_____

_____

_____

Birth date

| Year | Month | Day |
|---|---|---|
| ☐☐ | ☐☐ | ☐☐ |
| ☐☐ | ☐☐ | ☐☐ |
| ☐☐ | ☐☐ | ☐☐ |
| ☐☐ | ☐☐ | ☐☐ |

Street Address _____

City _____ Province _____ Country _____

Postal Code ☐☐☐ ☐☐☐ Telephone ☐☐☐ - ☐☐☐ - ☐☐☐☐

_____

Subscriber signature

By signing this claim form and/or submitting actual receipts, I agree that the information provided is complete and accurate, to the best of my knowledge. I authorize Green Shield Canada to exchange information with other parties as required and only when the information is needed to administer this benefit claim and/or to confirm the accuracy of this information.