

CLAIM FORM FOR GOVERNMENT HEALTH INSURANCE REPLACEMENT COVERAGE (VS PLAN)

Green Shield Canada Travel Assistance, Mondial Assistance
4273 King St. East, Kitchener, ON N2P 2E9 For claim inquiries: 1-800-363-1835

HOW TO CLAIM

- Physician Services:** Complete sections 1, 2 and 7 of this form and forward it to the address above.
Hospital Services: Complete sections 1, 3 and 7 of this form and forward it with itemized statements to the address above.
Commercial Lab: Complete sections 1, 4 and 7 of this form and forward it to the address above.
Ambulance Services: Complete sections 1, 5 and 7 of this form and forward it to the address above.
Other Services: Complete sections 1, 6 and 7 of this form and forward it to the address above.

SECTION 1 PATIENT AND PROVIDER INFORMATION

<p>Patient Information</p> <p>Name _____ Date of Birth _____</p> <p>Address _____</p> <p>Green Shield Identification Number _____</p> <p>Group Name _____</p>	<p>Provider Information Provider No. _____</p> <p>Name _____</p> <p>Address _____</p> <p>Telephone Number _____</p> <p>Physician <input type="checkbox"/> Hospital <input type="checkbox"/> Commercial Lab <input type="checkbox"/></p> <p>Ambulance <input type="checkbox"/> Other (Please Specify) _____</p>
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SECTION 2 PHYSICIAN FEES (office, home, institution or hospital services)

Description of Treatment Rendered	Diagnosis Code	Assessment Code	Date of Treatment (Yr Mo Dy)	Total Charge

SECTION 3 HOSPITAL SERVICES (A - inpatient charges, B - outpatient/emergency charges)

	Admission Date (Yr Mo Dy)	Discharge Date (Yr Mo Dy)	Diagnosis Code	Room Type (Active/acute, Chronic, Rehab)	Rate per day	No of days	Total Charge
A							
B	Description of Treatment Rendered			Diagnosis Code	Date of Treatment (Yr Mo Dy)		Total Charge

SECTION 4 COMMERCIAL LAB/X-RAYS

Description of Treatment Rendered	Service Code	Date of Treatment (Yr Mo Dy)	Total Charge

SECTION 5 AMBULANCE SERVICES

Reason for ambulance trip	Date of Service	Ambulance taken From	Ambulance taken To	Total Charge

SECTION 6 OTHER SERVICES

Description of Treatment Rendered	Date of Treatment (Yr Mo Dy)	Total Charge

SECTION 7 AUTHORIZATION AND DIRECTION

Were the above services required as a result of a motor vehicle accident? Yes ___ No ___

Were the above services required as a result of a work related accident? Yes ___ No ___

I certify that the treatment described above was performed and all information provided on this form is accurate.	The charges listed on this claim have been paid in full by the subscriber. Please reimburse the subscriber directly.	I certify that the above treatment was rendered and hereby authorize payment for eligible services directly to the provider named above
Signature of Provider Designation/Registration #	Signature of Provider	Signature of Patient/Guardian

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.