

PO Box 1623, Windsor, Ontario N9A 7B3
Attn: EHS Department
Customer Service Centre
1-888-711-1119 or (519) 739-1133
Fax (519) 739-0046

To the Patient: The details requested below are mandatory in order for Green Shield to determine our liability with respect to this request for oxygen equipment/supplies. For prior approval, please forward this request to the address indicated below. Failure to submit this authorization for pre-approval may result in a denial of your claim.

SECTION I - MUST BE COMPLETED IN FULL BY THE PATIENT/GUARDIAN

Patient's Name _____	Date of Birth ____/____/____ Age _____
Address _____	Green Shield No. _____
_____	Telephone No. _____
_____	E-Mail Address _____

Do you have any other Group Insurance coverage that may include these services as benefits? Yes No
If yes, please provide Insurance Company name _____
If other coverage is Green Shield, indicate Green Shield number _____

SECTION II - MUST BE COMPLETED IN FULL BY THE PHYSICIAN

- 1) This application is: Renewal New. If new, what is the set up date? _____
- 2) Diagnosis (Please be specific) _____
- 3) Has application been made to the Ministry of Health for Funding? Yes No
If No, please provide reason. _____
(If application has been made and funding denied, please attach their denial letter.)
- 4) The patient has appropriately tried other treatment measures without success. Yes No
If Yes, please describe. _____
- 5) Method of Supply:
() concentrator (including back-up and portable cylinders)
() cylinder (compressed oxygen for stationary and/or portability)
- 6) Anticipated hours per use (each day) _____
- 7) Name of Oxygen Vendor (if available) _____
- 8) I am receiving the following social assistance benefit (check all that apply):
 Ontario Works (OW) Ontario Disability Support Program (ODSP)
 Assistance to Children with Disabilities (ACSD) I am residing in a Long-Term Care Facility.
 I am receiving professional services through a community Care Access Centre
- 9) Does this person smoke? Yes No
If yes, are they planning to stop? _____
- 10) Is oxygen required: As a result of a work related injury? Yes No
As a result of a motor vehicle accident? Yes No For sports purposes only? Yes No

PLEASE ATTACH COPIES OF ARTERIAL BLOOD GASES AND/OR OXIMETRY READINGS WITH THIS REQUEST.

Physician's Signature () G.P. () Specialist Date _____

Physician's Name (please print) Physician Phone No. _____

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.

ALL CLAIMS MUST BE RECEIVED BY GREEN SHIELD CANADA WITHIN 12 MONTHS OF THE DATE OF SERVICE.
THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/SUBSCRIBER.