

**CLAIM FORM FOR IN HOME SUPPORT
SERVICES OF AN RN, RNA, RPN, PNA, LPN,
PERSONAL SUPPORT WORKER**

GREEN SHIELD NO.	PROVIDER NO.
PATIENT NAME INITIAL	NURSING REGISTRY
ADDRESS	ADDRESS CITY PROVINCE
CITY PROVINCE POSTAL CODE	POSTAL CODE TELEPHONE NO.

DO YOU HAVE ANY OTHER GROUP INSURANCE COVERAGE THAT MAY INCLUDE THESE SERVICES AS BENEFITS? YES NO

IF YES, INSURANCE COMPANY NAME _____

IF OTHER COVERAGE IS GREEN SHIELD, INDICATE GREEN SHIELD NUMBER: _____

IS TREATMENT REQUIRED DUE TO A MOTOR VEHICLE ACCIDENT? YES NO DATE OF ACCIDENT: _____

IS TREATMENT REQUIRED DUE TO A WORK RELATED INJURY? YES NO

IS TREATMENT RELATED TO AN OPEN WORKER'S COMPENSATION CLAIM? YES NO DATE OF INJURY: _____

SERVICES WERE PROVIDED BY: RN RNA/RPN PERSONAL SUPPORT WORKER RN/RPN FOOTCARE

DURING THE WEEK COMMENCING SUNDAY _____, _____ TO SATURDAY, _____, _____ ACCORDING TO THE FOLLOWING SCHEDULE:

DATE	HOURS WORKED (INDICATE A.M. OR P.M.)				HOURLY RATE	NUMBER OF HOURS	TOTAL CHARGE PER SHIFT	NAME OF INDIVIDUAL PROVIDING CARE	REGISTRATION NUMBER (IF APPLICABLE)
	A.M.	P.M.	A.M.	P.M.					
SUNDAY			TO						
MONDAY			TO						
TUESDAY			TO						
WEDNESDAY			TO						
THURSDAY			TO						
FRIDAY			TO						
SATURDAY			TO						
SUNDAY			TO						
MONDAY			TO						
TUESDAY			TO						
WEDNESDAY			TO						
THURSDAY			TO						
FRIDAY			TO						
SATURDAY			TO						

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.

I CERTIFY THAT THE TREATMENT OUTLINED WAS PERFORMED IN THE PATIENT'S HOME AND ALL INFORMATION PROVIDED ON THIS FORM IS ACCURATE.

THE CHARGES LISTED ON THIS CLAIM HAVE BEEN PAID IN FULL. PLEASE REIMBURSE THE PLAN MEMBER DIRECTLY.

I CERTIFY THAT THE ABOVE TREATMENT WAS RENDERED. PLEASE DIRECT PAYMENT TO THE PROVIDER INDICATED ABOVE.

SIGNATURE OF NURSING REGISTRY OFFICIAL

SIGNATURE OF NURSING REGISTRY OFFICIAL

SIGNATURE OF PATIENT/GUARDIAN

THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/PLAN MEMBER.
ALL CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS OF THE DATE OF SERVICE (unless otherwise stated in your benefit plan documentation).

PLEASE MAIL TO: GREEN SHIELD CANADA
P.O. BOX 1606, WINDSOR, ON N9A 6W1
ATTENTION: EHS DEPARTMENT
CUSTOMER SERVICE CENTRE 1-888-711-1119 or (519) 739-1133