

Please use one form per practitioner, per patient. There is no need to attach receipts if this form is completed in full by provider.

SECTION 1 – PATIENT INFORMATION				PROVIDER INFORMATION			
GREEN SHIELD ID NUMBER		COMPANY NAME		PROVIDER NUMBER		PROVIDER PHONE #	
SURNAME		FIRST NAME		DATE OF BIRTH (YY/MM/DD)		PROVIDER NAME	
ADDRESS				ADDRESS			
CITY		PROVINCE		POSTAL CODE		CITY	
						PROVINCE	
						POSTAL CODE	

**SECTION 2 – MANDATORY DECLARATION**

Do you have any other group insurance coverage that may include these services as benefits? YES  NO

If Yes, please provide Insurance company's name \_\_\_\_\_ **AND attach copy of statement from primary carrier.**

If other coverage is Green Shield, indicate Green Shield ID number: \_\_\_\_\_

Is treatment due to a motor vehicle accident? YES  NO  Date of Accident (YY/MM/DD) \_\_\_\_\_

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 (YY/MM/DD) \_\_\_\_\_

**SECTION 3 a – EYE EXAM CLAIM DETAILS (ONLY IF INCLUDED WITH THIS SUBMISSION)**

EYE EXAM	<input style="width:100%;" type="text"/>	PROVIDER NUMBER	<input style="width:100%;" type="text"/>
	YEAR MONTH DAY		
AMOUNT \$	<input style="width:100%;" type="text"/>	PAY PLAN MEMBER	<input type="checkbox"/>
		PAY PROVIDER	<input type="checkbox"/>
OPTOMETRIST NAME, ADDRESS & PHONE NUMBER			
<input style="width:100%; height:100%;" type="text"/>			

**SECTION 3b – EYEWEAR CLAIM DETAILS**

CHARGES		DATE OF PICK UP FOR EYEWEAR: _____				
FRAMES		YEAR			MONTH DAY	
EYEGLOSS LENSES		SPHERE	CYLINDER	AXIS	PRISM	<b>MUST BE COMPLETED IN ALL CASES BY SUPPLIER:</b> <input type="checkbox"/> New Prescription <input type="checkbox"/> Safety Glasses <input type="checkbox"/> Lenses Only <input type="checkbox"/> Post Cataract claim  If Post Cataract claim, does patient have lens implant? <input type="checkbox"/> Yes <input type="checkbox"/> No
CONTACT LENSES		R				
DISPENSING FEE		L				
MISC./DIAGNOSTIC TEST		BIFOCAL	PROGRESSIVE BIFOCAL	TRIFOCAL	TINT	
1. _____					Colour & No	
2. _____		R	R	R		
<b>TOTAL</b>		L	L	L		
<b>PATIENT PAID</b>		<b>CONTACT LENSES:</b> Can visual acuity be restored to at least 20/70 in the better eye with conventional eye glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Can visual acuity be restored to at least 20/40 in the better eye with conventional eye glasses? <input type="checkbox"/> Yes <input type="checkbox"/> No Are they medically necessary due to keratoconus, irregular astigmatism or irregular corneal curvature? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>BALANCE TO PROVIDER</b>						

**SECTION 4 – AUTHORIZATION**

I UNDERSTAND THAT THE CHARGES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY BENEFIT PLAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE SUPPLIER FOR THE COST OF THOSE SERVICES.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN _____  THE CHARGES LISTED ON THIS CLAIM HAVE BEEN PAID IN FULL BY THE PATIENT. PLEASE REIMBURSE PATIENT DIRECTLY.	COMPLETE THIS SECTION ON THE DATE OF PICK UP. I CERTIFY THAT THE ABOVE TREATMENT WAS RENDERED AND HEREBY ASSIGN PAYMENT DIRECTLY TO THE PROVIDER.  SIGNATURE OF PATIENT OR LEGAL GUARDIAN _____
SIGNATURE OF PROVIDER _____	

By signing this claim form and/or submitting original 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 authorize the release of the information contained on this form. 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.

**SECTION 5 – MAILING INSTRUCTIONS**

PLEASE ATTACH ALL ORIGINAL CORRESPONDENCE and retain copies for your files as original receipts will not be returned. ALL CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS OF THE DATE OF SERVICE (unless otherwise stated in your benefit plan documentation). THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/PLAN MEMBER.

CUSTOMER SERVICE CENTRE 1-888-711-1119 or (519) 739-1133 EMAIL ADDRESS WWW.GREENSHIELD.CA  
 PLEASE INDICATE ON MAILING ENVELOPE: GREEN SHIELD CANADA P.O. BOX 1615, WINDSOR, ON N9A 7J3 **ATTENTION: VISION DEPARTMENT**