*NO STAPLES PLEASE, PAPER CLIPS ONLY

GENERAL CLAIM SUBMISSION FORM
(For Drug and Extended Health Claims)
Non-Union, CUPE 79 and CUPE 416 Employees

SECTION 1 - PLAN MEMBER INFORMATION

GREEN SHIELD CANADA ID NUMBER	EMAIL ADDRESS
SURNAME FIRST NAME	PHONE NUMBER
ADDRESS	COMPANY NAME **CITY OF TORONTO**
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 _____

If other coverage is with Green Shield Canada, indicate other Green Shield Canada ID number: _____

Do you want to coordinate this claim with your other Green Shield Canada Coverage? **YES** ☐ **NO** ☐

Do you want to coordinate this claim with your Health Care Spending Account (if applicable)? **YES** ☐ **NO** ☐

Is treatment due to a motor vehicle accident? YES ☐ NO ☐ If yes, Date of Accident (YY/MM/DD) _____

Is treatment required due to a work related injury? YES ☐ NO ☐ If yes, Date of Injury (YY/MM/DD) _____WSIB / WCB Case # _____

SECTION 3 - CLAIM DETAILS

PATIENT'S NAME (Only include names of patients with receipts attached)	DEPENDENT NO. (-00, -01, -02)	DATE OF BIRTH YR	MO	DAY	PROFESSIONAL/ SUPPLIER'S NAME and Provider Number (if available)	DATE OF CLAIM YR	MO	DAY	TYPE OF EXPENSE	TOTAL AMOUNT CHARGED PER VISIT/ ITEM

FOR PARAMEDICAL PRACTITIONER EXPENSES:

NOT APPLICABLE TO NON-UNION / ACCOUNTABILITY OFFICERS / ELECTED OFFICIALS, FIREFIGHTERES' AND CUPE LOCAL 79 RECREATION WORKERS

For the following practitioners (e.g. Chiropractor, Massage Therapist) choose only ONE of the coverage options:

☐ **Option 1: the current maximum per practitioner per person, per benefit year OR, alternatively**

☐ **Option 2: a maximum of $800 for one (1) practitioner per person, per benefit year**

If option 2 is selected, please indicate the practitioner type here _____, benefit year _____, and Patient's Name _____

For practitioner / paramedical expenses please attach an itemized receipt stating:

- **Patient Name,**
- **Length of visit,**
- **Charge for treatment,**
- **Date of service, and**
- **Names of practitioner,**
- **Type of practitioner,**
- **Date last paid by province plan (if applicable)**
- **License and/or registration number**

SECTION 4 - AUTHORIZATION

I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for the purpose of claims adjudication and any other services necessary in the administration of our benefits. I understand that this information may be seen by the cardholder. I understand that the information provided by me to Green Shield Canada about myself and my dependents, will be used by Green Shield Canada for these purposes.

In the event of suspected fraudulent activity pertaining to claims submitted on behalf of myself and/or my dependents, I understand that Green Shield Canada may disclose this information to regulatory and law enforcement agencies, as required by law. If there are reasonable grounds to believe that false or misleading information has been submitted, this may result in Green Shield Canada releasing relevant information from my claim file to my employer for the purposes outlined in this authorization.

I certify that the information in this form and in any supporting documentation is true and complete, to the best of my knowledge. I agree that my claim may be denied as a result of my providing false, incomplete or misleading information.

I authorize any physician, health care/service provider, pharmacy, rehabilitation provider, medically-related facility, insurance company, any type of workers' compensation board, administrators of government benefits, the medical information bureau and investigative agency, the City's Employee Health and Rehabilitation Services and my plan sponsor, or other similar persons or entities who have information related to my claim, to release, discuss and exchange information requested by Green Shield Canada, only insofar as any such information is needed for the purpose of claims adjudication and the administration of benefits.

I authorize Green Shield Canada, its reinsurers and its service providers to collect, to use, to maintain and disclose to the persons to whom I have granted access and/or each other any information, only insofar as any such information is needed for the purposes of group benefits plan administration, audit, and the assessment, investigation and management of my claim.

I agree that photocopy, fax, or electronic versions of this authorization shall be as valid as the original.

At Green Shield Canada, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a Group Life and Health Benefits file. Access to your information will be limited to:

• our employees and representatives in the performance of their jobs; • persons to whom you have granted access; and • persons authorized by law
You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information.

_____ _____

SIGNATURE OF PLAN MEMBER DATE

SECTION 5 - MAILING INSTRUCTIONS

ALL CLAIMS MUST BE RECEIVED WITHIN 12 MONTHS OF THE DATE OF SERVICE (unless otherwise stated in your benefit plan documentation). PLEASE ATTACH ALL ORIGINAL DOCUMENTATION and retain copies for your files as original receipts will not be returned. Send your claim to the corresponding address below (be sure to indicate the full address on the envelope):

PROFESSIONAL SERVICES	MEDICAL ITEMS	VISION & ACCOMMODATION	DRUG	OTHER CLAIMS
P.O. BOX 1699 WINDSOR, ON N9A 7G6	P.O. BOX 1623 WINDSOR, ON N9A 7B3	P.O. BOX 1615 WINDSOR, ON N9A 7J3	P.O. BOX 1652 WINDSOR, ON N9A 7G5	P.O. BOX 1606 WINDSOR, ON N9A 6W1

To avoid additional postage costs, please submit multiple claims in one envelope to any of the addresses listed above. When in doubt, choose the "OTHER CLAIMS" address.

CUSTOMER SERVICE CENTRE 1-844-997-9888 or (519) 739-1133 **greenshield.ca**

GREEN SHIELD CANADA CLAIM SUBMISSION INSTRUCTIONS

Please call our Customer Service Centre at 1-844-997-9888 if you require any assistance in completing this form.
Please ensure that you always provide your Green Shield Canada ID Number in full, including suffix (ie. 00, 01, etc.)

FOR BENEFIT TYPE (where applicable):	ALWAYS ENCLOSE THE FOLLOWING ITEMS WITH THE ABOVE CLAIM FORM:
Audio (Hearing Aids)	Itemized receipts showing • patient name • services & dates • audiologist name & address • breakdown of charges (i.e. Acquisition cost, fee, mold)
Prescription Drugs	All itemized prescription drug receipts from your pharmacist. Please note cash register receipts, credit card receipts and/or debit slips alone are insufficient. Official pharmacy receipts are required. Please contact your pharmacy for a duplicate copy. **FOR PRESCRIPTION DRUG CLAIMS ONLY:** **TO FACILITATE CLAIMS PROCESSING:** • **Please note: Cash register receipts, credit card receipts and/or debit slips alone are insufficient. Official pharmacy receipts are required.** • **Original receipts must contain patient's name, date of service, Rx number, drug name, quantity dispensed and Drug Identification Number (DIN)** • **If injectable, please provide breakdown of quantity dispensed, drug cost and administration fees.** **If claim is from OUT OF COUNTRY, please provide:** **Name of Country Visited** _____ **Currency Used** _____ **Name of Drug** _____
Durable Medical Equipment (including prosthetics)	Itemized receipts showing • patient name • a detailed description of the equipment • name & address of supplier • date & charge for each service Some medical equipment may require a medical referral/physician prescription and/or prior authorization.
Custom Foot Orthotics	Itemized receipts showing • patient name • name and address of supplier • charge for service • casting technique • date orthotics were received A prescription with diagnosis as well as Biomechanical Exam or Gait Analysis and a copy of the lab invoice is required. Above items are required unless otherwise specified by your plan sponsor.
Hospital Accommodation	Itemized receipts showing • patient name • number of days in semi-private/private accommodation • rate charged per day • admission & discharge dates
Vision Care	Itemized receipts showing • patient name • copy of vision prescription • a breakdown of charges for lenses & frames • date eyewear received or paid in full
Extended Health - General	Itemized receipts showing • patient name • a detailed description of services or supplies • provider's name & address • date & charge for each service Certain types of service or supplies may require a medical referral/physician prescription and/or prior authorization.
Out of Province/Country	Call Customer Service at 1-844-997-9888 for detailed claims submission instructions.
Private Duty Nursing	Call Customer Service at 1-844-997-9888 for detailed claims submission instructions. Pre-approval is required for all nursing claims - call Customer Service for details.