CLAIM FORM FOR RELATED HEALTH PROFESSIONAL SERVICES

PROFESSIONAL TYPE CODES * May not be applicable to all plan members of Green Shield Canada.

1	PODIATRIST	**6**	CLINICAL PSYCHOLOGIST *	**10**	OSTEOPATH	**15**	HOMEOPATH
2	CHIROPODIST	**7**	NATUROPATH	**11**	DIETICIAN *	**16**	CHRISTIAN SCIENCE PRACTITIONER
3	CHIROPRACTOR	**8**	SPEECH THERAPIST/PATHOLOGIST *	**12**	CERTIFIED ATHLETIC THERAPIST *	**17**	MUSCLE PHYSIOLOGIST *
4	PHYSIOTHERAPIST *	**9**	ACUPUNCTURE (PHYSICIAN OR SURGEON)	**13**	SHIATSU THERAPIST *	**18**	COUNSELLOR
5	REGISTERED MASSAGE THERAPIST *			**14**	OCCUPATIONAL THERAPIST	**19**	OTHER - Specify

*** PHYSICIAN'S AUTHORIZATION MAY BE REQUIRED ON INITIAL CLAIM FOR PROFESSIONAL TYPE CODES 4, 5, 8, 11, 12, 13, 17**

PLEASE NOTE: This claim form cannot be used for supplies of any type, only services or treatments. Please use one form per practitioner, as well as per patient.

PROVIDER

GREEN SHIELD PROVIDER NO. OF PRACTITIONER

PROVIDER PHONE NO. ( )

NAME OF PRACTITIONER

PROFESSION TYPE CODE - Please specify (refer to above).

ADDRESS

CITY **PROV.** **POSTAL CODE**

PATIENT

GREEN SHIELD PATIENT # **DEP #** **COMPANY NAME**

SURNAME **FIRST NAME** **BIRTH DATE** _____/_____/_____ YY MO DAY

ADDRESS

CITY **PROV.** **POSTAL CODE**

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.

CLAIM ONLY FOR THOSE SERVICES RENDERED AFTER PROVINCIAL PLAN MAXIMUM HAS BEEN EXHAUSTED (IF APPLICABLE)

DATE OF LAST VISIT COVERED BY PROVINCIAL PLAN _____/_____/_____ YR MO DAY

	TREATMENT RENDERED (# OF HOURS - if applicable)	YR	MO	DAY	TAX INC. Y or N	CHARGES $
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
	TOTAL					

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 ☐

DATE OF INJURY _____

I CERTIFY THAT THE TREATMENT DESCRIBED ABOVE WAS PERFORMED BY ME AND ALL INFORMATION PROVIDED ON THIS FORM IS ACCURATE.

SIGNATURE OF PROVIDER **REGISTRATION NO., CREDENTIALS & ASSOCIATION**

I CERTIFY THAT THE ABOVE TREATMENTS WERE RENDERED.

PATIENT SIGNATURE

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

I CERTIFY THAT THE ABOVE TREATMENT WAS RENDERED AND HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE PROVIDER NAMED ABOVE.

SIGNATURE OF PROVIDER **SIGNATURE OF PATIENT**

Patient Diagnosis _____

THERE IS NO NEED TO ATTACH INVOICES OR RECEIPTS IF THIS FORM IS FULLY COMPLETED BY THE SERVICE PROVIDER

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).

GREEN SHIELD CANADA
P.O. BOX 1699, WINDSOR, ONTARIO N9A 7G6
ATTENTION: EHS DEPARTMENT
CUSTOMER SERVICE CENTRE 1-888-711-1119 or (519) 739-1133