GREEN SHIELD CANADA

PLEASE USE THIS FOR YOUR NEXT CLAIM SUBMISSION

PLEASE INDICATE ON MAILING ENVELOPE

Attn: Drug Dept. P.O. Box 1652, Windsor ON N9A 7G5
Attn: Professional Services P.O. Box 1699, Windsor ON N9A 7G6
Attn: Medical Items P.O. Box 1623, Windsor ON N9A 7B3
Attn: Out-of-Country Dept. P.O. Box 1606, Windsor ON N9A 6W1
Attn: Vision/Hospital Dept. P.O. Box 1615, Windsor ON N9A 7J3
Attn: Dental Dept. P.O. Box 1608, Windsor ON N9A 7G1

FOR CLAIMS REQUIRING FORM COMPLETION, REQUEST FORMS FROM CUSTOMER SERVICE:
EHS Services/Medical Equipment/ Supplies/Vision/Hospital/Nursing Home

CUSTOMER SERVICE CENTRE
1 888 711-1119

CLAIM SUBMISSION FORM

Mandatory Declaration

Do you have any other group insurance coverage that may include the claim as a benefit?

Yes ☐ No ☐

If yes, please indicate name of other insuring agency:

If other coverage is Green Shield, indicate Green Shield Identification No.:

Submit copies of other carrier's statement along with copies of corresponding receipts.

Are any of the enclosed claims due to:

1. A work related injury Yes ☐ No ☐
2. A Motor Vehicle Accident Yes ☐ No ☐

If "Yes" please indicate the date of the accident (loss):

Subscriber surname including alternate surname if applicable

Company Name

Green Shield Identification Number

Only include names of patients with receipts attached.

Patient's First Name

Birth date Year Month Day

Street Address

City Province Country

Postal Code Telephone

PLEASE INCLUDE ORIGINAL PAID RECEIPTS

Subscriber signature

By signing this claim form and/or submitting actual receipts, I agree that the information provided is complete and accurate, to the best of my knowledge. I authorize Green Shield Canada to exchange information with other parties as required and only when the information is needed to administer this benefit claim and/or to confirm the accuracy of this information.

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