

## 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 CO					CODE	DE POSTAL CODE				TELEPHONE NO.		
SERVICES WERE PROVIDED BY AN RN RNA/RPN PERSONAL SUNDAY RNA/RPN PERSONAL ACC												
DATE	HOURS WORKED (INDICATE A.M. OR P.M. A.M. P.M. A.M.			I. OR P.M.	DATE			NUMBER OF HOURS	TOTAL CHARGE PER SHIFT	NAME OF INDIVIDUAL PROVIDING CARE	REGISTRATION NUMBER (IF APPLICABLE)	
SUNDAY			то									
SUNDAY			то									
MONDAY			то									
MONDAY			то									
TUESDAY			то									
TUESDAY			то									
WEDNESDAY			то									
WEDNESDAY			то									
THURSDAY			то									
THURSDAY			то									
FRIDAY			то									
FRIDAY			то									
SATURDAY			то									
SATURDAY			то									
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.												
						PAID IN F	ULI	L. PLEASE R	S CLAIM HAVE EIMBURSE THE	I CERTIFY THAT THE ABOVE TREATMENT WAS RENDERED. PLEASE DIRECT PAYMENT TO THE PROVIDER INDICATED ABOVE.		
SIGNATURE OF NURSING REGISTRY OFFICIAL S						SIGNATURE OF NURSING REGISTRY OFFICIAL				SIGNATURE OF PATIENT/GUARDIAN		

THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/SUBSCRIBER. ALL CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS OF THE DATE OF SERVICE.

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

Claim Form for in Home Support Services of an RN etc -EN (Rev, 2006-12)