GREEN SHIELD
C A N A D A

DRUG CLAIM SUBMISSION FORM

A. SUBSCRIBER INFORMATION

Subscriber Surname

Green Shield I.D. #

Street Address	City	Province	Postal Code

Home Telephone # ( )	Work Telephone # ( )	E-mail Address	Name of Employer

B. MANDATORY DECLARATION

1. Are any of the expenses being claimed covered by another group insurance plan?   ___ No ___ Yes If yes, complete the following information about **the person who is the MEMBER under the other plan: (If claiming coordination of benefits, please provide alternate carrier's explanation of benefits with receipt copies).**

  Other Member's Name _____
  (in full)

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

2. Are any of the expenses being claimed due to:
  A.   A work related injury?   ____ No ____ Yes   If yes, date of injury
  (yr/mm/dd)

  B.   A motor vehicle accident?   ____ No ____ Yes   If yes, date of accident

C. CLAIMANT   (Only include names of patients with receipts attached.)

Patient's First Name	Dep#	Date of Birth (yr/mm/dd)	Pharmacy Name	Location	Phone #

D. TO FACILITATE CLAIM PROCESSING

  ♦   If claim is from **out of country**, please provide:
    -   Name of country visited _____
    -   Currency Used _____

  ♦   Please note, cash register receipts & credit card/debit slips are insufficient. Please contact your pharmacy for duplicate receipts.

  ♦   Original receipts must contain claimant's name, date of service, drug name and Drug Identification Number (DIN).

  ♦   Manual submission of this claim may not be required. Please check with your pharmacist regarding on-line claim submission.

E. AUTHORIZATION

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.

Subscriber's Signature **X**   Date

Please mail to the attention of :   Drug Dept.
P.O. Box 1652, Windsor, Ontario N9A 7G5

PLEASE ATTACH ALL ORIGINAL PAID RECEIPTS
Please retain copies for your files as original receipts will not be returned

The intentional falsification, misrepresentation or omission of information on or relating to this claim constitutes fraud.
ALL CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS OF THE DATE OF SERVICE.