AUTHORIZATION FORM FOR GLUCOSE MONITORING SYSTEM

PO Box 1623, Windsor, Ontario N9A 7B3
Attn: EHS Department
Customer Service Centre
1-888-711-1119 or (519) 739-1133
Fax (519) 739-0046
Email: medical.authorization@greenshield.ca

To the Patient: The details requested below are mandatory in order for Green Shield to determine our liability with respect to this request. For prior approval, please forward this form to the address indicated. A response Explanation of Benefits statement outlining our liability will be forwarded to the patient promptly. Our decision is not intended to interfere with or reflect upon the course of treatment recommended by your doctor. Failure to request pre-approval may result in a denial of your claim.

SECTION I - MUST BE COMPLETED IN FULL BY THE PATIENT/GUARDIAN

Patient's Name _____ **Date of Birth** _____/_____/_____ **Age** _____

Address _____ **Green Shield No.**

_____ **Telephone No.**

_____

E-Mail Address

Do you have any other Group Insurance coverage that may include these services as benefits? Yes ☐ No ☐
If yes, please provide Insurance Company name
If other coverage is Green Shield, indicate Green Shield number

I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.

By signing this claim form and/or submitting actual receipts, I agree that the information provided is complete and accurate. 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 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 further authorize Green Shield Canada to obtain and exchange information with other parties, such as health practitioners or insurers, in order to confirm the accuracy of the submitted claim(s) information. In the event of suspected fraudulent activity pertaining to claims submitted on behalf of myself and/or my dependents, I acknowledge and agree to the disclosure of this information to relevant parties, such as the Plan Sponsor, regulatory and law enforcement agencies.

Date **Signature of Patient**

(If under 16 years of age, the signature of the parent / guardian is required.)

SECTION II - MUST BE COMPLETED IN FULL BY THE PHYSICIAN

1) Has the patient been diagnosed with Insulin Dependent Diabetes Mellitus? Yes ☐ No ☐

2) Is the patient currently using an insulin pump? Yes ☐ No ☐

3) How many times per day is the patient testing their blood glucose using a self-monitoring blood glucose meter?

_____ times per day

What insulin is the patient using? List all below:

1) _____
2) _____
3) _____

***Please Note: if you are approved for a Glucose Monitoring System, your reimbursement for test strips for a self-monitoring blood glucose meter will be limited to 600 strips per year**

Physician's Signature _____ **(** **) G.P. (** **) Specialist Date** _____

_____ _____

Physician's Name (Please print) **Physician's Phone No.**

ALL CLAIMS MUST BE RECEIVED BY GREEN SHIELD CANADA WITHIN 12 MONTHS OF THE DATE OF SERVICE (unless otherwise stated in your benefit plan documentation).
THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/PLAN MEMBER