*NO STAPLES PLEASE, PAPER CLIPS ONLY

GENERAL CLAIM SUBMISSION FORM
(For Drug and Extended Health Claims)

SECTION 1 - PLAN MEMBER INFORMATION

GREEN SHIELD CANADA ID NUMBER	EMAIL ADDRESS
SURNAME FIRST NAME	PHONE NUMBER
ADDRESS	COMPANY NAME **TTC - Toronto Transit Commission**
CITY PROVINCE	POSTAL CODE

SECTION 2 - MANDATORY DECLARATION

Do you have any other group insurance coverage that may include these services as benefits? **YES** ☐ **NO** ☐

If Yes, please provide Insurance company's name _____

If other coverage is with Green Shield Canada, indicate other Green Shield Canada ID number: _____

Do you want to coordinate this claim with your other Green Shield Canada Coverage? **YES** ☐ **NO** ☐

Is treatment due to a motor vehicle accident? YES ☐ NO ☐ If yes, Date of Accident (YY/MM/DD)_____

Is treatment required due to a work related injury? YES ☐ NO ☐ If yes, Date of Injury (YY/MM/DD) _____

If yes, WSIB / WCB Case # _____

SECTION 3 - CLAIM DETAILS

PATIENT'S NAME (Only include names of patients with receipts attached)	DEPENDENT NO. (-00, -01, -02)	DATE OF BIRTH YR	MO	DAY	PARAMEDICAL SERVICES/ SUPPLIER'S NAME and Provider Number (if available)	DATE OF CLAIM YR	MO	DAY	TYPE OF EXPENSE	TOTAL AMOUNT CHARGED PER VISIT/ ITEM

GREEN SHIELD CANADA CLAIM SUBMISSION INSTRUCTIONS

Please call our Customer Service Centre at 1-888-711-1119 if you require any assistance in completing this form.
Please ensure that you always provide your Green Shield Canada ID Number in full, including suffix (ie. 00, 01, etc.)
Please refer to the reverse side of this claim form for items that should accompany this form.

SECTION 4 - AUTHORIZATION

I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for the purpose of claims adjudication and any other services necessary in the administration of our benefits. I understand that this information may be seen by the cardholder. 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 these purposes.

In the event of suspected, improper or 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.

I certify that the information in this form and any further verbal or written statement provided by me in the future, is true and complete, to the best of my knowledge. I agree that both my claim and my coverage may be denied or terminated as a result of my providing false, incomplete or misleading information.

I authorize any health care provider, other insurance company, any type of workers' compensation board, my Plan Sponsor, or other persons to release, discuss and exchange information requested by Green Shield Canada, when the information is needed to process, adjudicate, litigate, arbitrate or audit this claim.

I authorize any person or organization who has personal information about me, including my employer, my Plan Sponsor, any group plan administrator, health care professional, health care institution, pharmacy and other medically-related facility, rehabilitation provider, insurer, administrators of government benefits or their benefits programs, the medical information bureau and investigative agency, to release my personal information to Green Shield Canada and/or its service providers for the purposes of group benefits plan administration, audit, and the assessment, investigation and management of my claim, including independent medical assessments. Such persons shall be considered persons to whom I have granted access for the purpose of this "agreement, authorization and consent."

I authorize Green Shield Canada, its reinsurers and its service providers to collect, to use, to maintain and disclose to the persons to whom I have granted access and/or each other any information needed for the purposes of group benefits plan administration, audit, and the assessment, investigation and management of my claim, including independent medical assessments.

I agree that photocopy, fax, or electronic versions of this authorization shall be as valid as the original.

At Green Shield Canada, we know that confidentiality of personal information is important. Any information you provide to us will be kept in a Group Life and Health Benefits file. Access to your information will be limited to:

• our employees and representatives in the performance of their jobs; • persons to whom you have granted access; and • persons authorized by law.

You have the right to request access to the personal information in your file and, if necessary, correct any inaccurate information.

_____ _____

SIGNATURE OF PLAN MEMBER DATE

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FOR BENEFIT TYPE (where applicable):	ALWAYS ENCLOSE THE FOLLOWING ITEMS WITH THE ABOVE CLAIM FORM:
Audio (Hearing Aids)	Itemized receipts showing • patient name • services & dates • audiologist name & address • breakdown of charges (i.e. Acquisition cost, fee, mold)
Prescription Drugs	All itemized prescription drug receipts from your pharmacist. Please note cash register receipts, credit card receipts and/or debit slips alone are insufficient. Official pharmacy receipts are required. Please contact your pharmacy for a duplicate copy. **FOR PRESCRIPTION DRUG CLAIMS ONLY:** **TO FACILITATE CLAIMS PROCESSING:** • **Please note: Cash register receipts, credit card receipts and/or debit slips alone are insufficient. Official pharmacy receipts are required.** • **Original receipts must contain patient's name, date of service, Rx number, drug name, quantity dispensed and Drug Identification Number (DIN)** • **If injectable, please provide breakdown of quantity dispensed, drug cost and administration fees.** **If claim is from OUT OF COUNTRY, please provide:** **Name of Country Visited** _____ **Currency Used** _____ **Name of Drug** _____
Professional Services (physiotherapy, chiropractor, massage therapy, etc.)	Itemized receipts showing • patient name • individual date & nature of treatment • charge for each service Some professional services may require a medical referral/physician prescription.
Durable Medical Equipment (including prosthetics)	Itemized receipts showing • patient name • a detailed description of the equipment • name & address of supplier • date & charge for each service Some medical equipment may require a medical referral/physician prescription and/or prior authorization.
Custom Foot Orthotics	Itemized receipts showing • patient name • name and address of supplier • charge for service • casting technique • date orthotics were received A prescription with diagnosis as well as Biomechanical Exam or Gait Analysis and a copy of the lab invoice is required. Above items are required unless otherwise specified by your Plan Sponsor.
Hospital Accommodation	Itemized receipts showing • patient name • number of days in semi-private/private accommodation • rate charged per day • admission & discharge dates
Vision Care	Itemized receipts showing • patient name • copy of vision prescription • a breakdown of charges for lenses & frames • date eyewear received or paid in full
Extended Health - General	Itemized receipts showing • patient name • a detailed description of services or supplies • provider's name & address • date & charge for each service Certain types of service or supplies may require a medical referral/physician prescription and/or prior authorization.
Out of Province/Country	See your benefits booklet for coverage details of your GSC out-of-country travel benefit. You may want to consider purchasing additional out-of-country coverage before you travel.
Private Duty Nursing	Call Customer Service at 1-888-711-1119 for detailed claims submission instructions. Pre-approval is required for all nursing claims - call Customer Service for details.

Note: Proof of payment is required to support your claim. If paying with cash be sure to get a receipt from the provider that specifies the item or service was paid in full. However, in some circumstances, we require that a traceable and identifiable form of payment be used, such as a cheque, debit or credit card, so that you can submit the confirmation of payment with your claim as proof that you received the item or service.

MAILING INSTRUCTIONS

ALL CLAIMS MUST BE RECEIVED WITHIN 90 DAYS FROM THE END OF THE CALENDAR YEAR IN WHICH THE EXPENSE WAS INCURRED OR 90 DAYS FROM THE DATE OF TERMINATION OF PLAN BENEFIT COVERAGE. PLEASE ATTACH ALL ORIGINAL DOCUMENTATION and retain copies for your files as original receipts will not be returned. Send your claim to the corresponding address below (be sure to indicate the full address on the envelope):

PROFESSIONAL SERVICES	MEDICAL ITEMS	VISION & ACCOMMODATION	DRUG	OTHER CLAIMS
P.O. BOX 1699	P.O. BOX 1623	P.O. BOX 1615	P.O. BOX 1652	P.O. BOX 1606
WINDSOR, ON	WINDSOR, ON	WINDSOR, ON	WINDSOR, ON	WINDSOR, ON
N9A 7G6	N9A 7B3	N9A 7J3	N9A 7G5	N9A 6W1

To avoid additional postage costs, please submit multiple claims in one envelope to any of the addresses listed above. When in doubt, choose the "OTHER CLAIMS" address.

CUSTOMER SERVICE CENTRE 1-888-711-1119 or (519) 739-1133 **greenshield.ca**