GREEN SHIELD CANADA

For claims requiring completion, request forms from our
CUSTOMER SERVICE CENTRE 1-888-711-1119

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 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.

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.