P.O. BOX 1615 WINDSOR, ONTARIO N9A 7J3
CUSTOMER SERVICE CENTRE 1-888-711-1119 OR (519) 739-1133

AUTHORIZATION FORM FOR POST-CATARACT SURGERY AND PROSTHETIC EYEWEAR

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

Plan Member Name ______________________ **Birth Date** ______ / ______ / ______ **Age** _____

Patient Name ______________________ **Green Shield No.** ______________________

Street Address ______________________ **Telephone No** ______________________

____

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 ______________________

SECTION II - MUST BE COMPLETED IN FULL BY PHYSICIAN

Ophthalmic disease or condition: ______________________

____

____

For cataract patients, please state the date of surgery:

Left Eye ______ / ______ / ______ Lens Implant? ___Yes ___No
Year Month Day

Right Eye ______ / ______ / ______ Lens Implant? ___Yes ___No
Year Month Day

The following prosthetic eyewear is required. **(Please include prescription details):** ______________________

____

____

____

____

____
Physician's Name (please print clearly)

____
Physician's Phone Number

____
Original Physician's Signature (stamp not accepted)

____
Date

THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/PLAN MEMBER.

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.

All claims must be submitted within 12 months of the date of service (unless otherwise stated in your benefit plan documentation).