

Benefit Type:

- | | | |
|--|---|-------------------------------------|
| <input type="checkbox"/> Drug | <input type="checkbox"/> Dental | <input type="checkbox"/> Audio |
| <input type="checkbox"/> Medical Items | <input type="checkbox"/> Professional Services | <input type="checkbox"/> Child Care |
| <input type="checkbox"/> Vision Care | <input type="checkbox"/> Hospital Accommodation | <input type="checkbox"/> _____ |

Provider Name:

Provider Number:

Patient Name:

Plan Member ID:

Date of Service:

Form I.D. # (Internal use Only):

Procedure Code / DIN:

Rx #:

Description of Product/Service:

Claim Paid Amount:

 Payee Type: ☐ Provider
☐ Plan Member

How did you receive payment from GreenShield?

☐ Cheque or ☐ EFT (direct deposit)

If applicable, what is the status of your cheque?

☐ Cashed or ☐ Not Cashed

If an overpayment has occurred, please check the following:

☐ Refund cheque payable to GreenShield will be sent

☐ GreenShield to apply a negative balance to your next provider bulk payment

Reversal Reason:

☐ Please reprocess original claim with requested change.

Requested By:

 Name of Authorized Individual (Please print)

 Telephone Number

 Signature

 Date

By signing this claim form, 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 Insurance will be used by Green Shield Canada Insurance for claims adjudication.

Please fax to: Green Shield Canada Insurance
1-519-739-0046