GreenShield™ Insurance

AUTHORIZATION FORM FOR OXYGEN EQUIPMENT AND SUPPLIES

P. O. 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 Canada Insurance to determine our liability with respect to this request for oxygen equipment/supplies. For prior approval, please forward this request to the address indicated below. Failure to submit this authorization for 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** _____ /_____ /_____
YY MM DD

Address _____ **Plan Member ID** _____

_____ **Telephone Number** _____

_____ **Email Address** _____

Do you have any other Group Insurance coverage that may include these services as benefits? Yes ☐ No ☐

If other coverage is Green Shield Canada Insurance, indicate other Plan Member ID: _____

SECTION II - MUST BE COMPLETED IN FULL BY PHYSICIAN

PLEASE ATTACH COPIES OF ARTERIAL BLOOD GASES AND/OR OXIMETRY READINGS WITH THIS REQUEST.

1) This application is: ☐ **Renewal** ☐ **New** **If new, what is the set up date?** _____

2) Diagnosis (please be specific): _____

_____

3) Has an application been made to the Ministry of Health for Funding? Yes ☐ No ☐

If No, please provide reason. _____

_____

(If application has been made and funding denied, please attach their denial letter.)

4) Method of Supply:

☐ Concentrator (including back-up and portable cylinders)

☐ Cylinder (compressed oxygen for stationary and/or portability)

5) Name of Oxygen Vendor (if available): _____

6) Is oxygen required: As a result of a work related injury? Yes ☐ No ☐

As a result of a motor vehicle accident? Yes ☐ No ☐ For sports purposes only? Yes ☐ No ☐

PLEASE ATTACH COPIES OF ARTERIAL BLOOD GASES AND/OR OXIMETRY READING WITH THIS REQUEST.

_____ ☐ G.P. ☐ Specialist _____

Physician's Signature Date

_____ _____

Physician's Name (Please Print) Physician's Phone 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 Insurance about myself and my dependents, will be used by Green Shield Canada Insurance 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 Insurance 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 lawenforcement agencies.

ALL CLAIMS MUST BE SUBMITTED 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.