AUTHORIZATION FORM FOR OXYGEN EQUIPMENT AND SUPPLIES

To the Patient: The details requested below are mandatory in order for Green Shield 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 1 - PLAN MEMBER INFORMATION

GREEN SHIELD CANADA ID NUMBER	EMAIL ADDRESS
SURNAME FIRST NAME	TELEPHONE NUMBER
ADDRESS	DATE OF BIRTH _____ / _____ / _____ AGE _____
CITY PROVINCE	POSTAL CODE

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: _____

SECTION 2 - MUST BE COMPLETED IN FULL BY THE 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 READINGS 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 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 RECEIVED 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.

Once completed, please return form as well as any other information to:

Green Shield Canada
Attn: EHS Department
P. O. BOX 1623
Windsor, ON N9A 7B3

Completed Forms can also be faxed or emailed: Fax: 1-519-739-0046 or Email: medical.authorization@greenshield.ca