CLAIM FORM FOR VISION CARE SERVICES

Please use one form per practitioner, per patient. There is no need to attach receipts if this form is completed in full by the provider.

SECTION 1 - PATIENT INFORMATION

GREEN SHIELD ID NUMBER	COMPANY NAME	PROVIDER NUMBER	PROVIDER PHONE #

SURNAME	FIRST NAME	DATE OF BIRTH (YY/MM/DD)

ADDRESS

CITY	PROVINCE	POSTAL CODE

PROVIDER INFORMATION

PROVIDER NAME

ADDRESS

CITY	PROVINCE	POSTAL CODE

SECTION 2 - MANDATORY DECLARATION

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 _____ **AND attach copy of statement from primary carrier.**

If other coverage is Green Shield, indicate Green Shield ID number: _____

Is treatment due to a motor vehicle accident? YES ☐ NO ☐ Date of Accident (YY/MM/DD) _____

Is treatment required due to a work related injury? YES ☐ NO ☐

Is treatment related to an open Worker's Compensation claim? YES ☐ NO ☐ Date of Injury (YY/MM/DD) _____

SECTION 3a - EYE EXAM CLAIM DETAILS (ONLY IF INCLUDED WITH THIS SUBMISSION)

EYE EXAM _____ YEAR MONTH DAY

AMOUNT $ _____

PROVIDER NUMBER _____

PAY PLAN MEMBER ☐

PAY PROVIDER ☐

OPTOMETRIST NAME, ADDRESS & PHONE NUMBER

SECTION 3b - EYEWEAR CLAIM DETAILS

CHARGES	
FRAMES	
EYEGLASS LENSES	
CONTACT LENSES	
DISPENSING FEE	
MISC./DIAGNOSTIC TEST 1. _____ 2. _____	
TOTAL	
PATIENT PAID	
BALANCE TO PROVIDER	

DATE EYEWEAR RECEIVED OR PAID IN FULL: _____
YEAR MONTH DAY

	SPHERE	CYLINDER	AXIS	PRISM
R				
L				

	BIFOCAL	PROGRESSIVE BIFOCAL	TRIFOCAL	TINT Colour & No
R				
L				

MUST BE COMPLETED IN ALL CASES BY SUPPLIER:

☐ New Prescription
☐ Safety Glasses
☐ Lenses Only
☐ Post Cataract claim

If Post Cataract claim, does patient have lens implant?
☐ YES ☐ NO

CONTACT LENSES:

Can visual acuity be restored to at least 20/70 in the better eye with conventional eye glasses? YES ☐ NO ☐

Can visual acuity be restored to at least 20/40 in the better eye with conventional eye glasses? YES ☐ NO ☐

Are they medically necessary due to keratoconus, irregular astigmatism or irregular corneal curvature? YES ☐ NO ☐

SECTION 4 - AUTHORIZATION

I UNDERSTAND THAT THE CHARGES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY BENEFIT PLAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE SUPPLIER FOR THE COST OF THOSE SERVICES.

_____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN

THE CHARGES LISTED ON THIS CLAIM HAVE BEEN PAID IN FULL BY THE PATIENT. PLEASE REIMBURSE PATIENT DIRECTLY.

_____
SIGNATURE OF PROVIDER

COMPLETE THIS SECTION ON THE DATE OF PICK UP. I CERTIFY THAT THE ABOVE TREATMENT WAS RENDERED AND HEREBY ASSIGN PAYMENT DIRECTLY TO THE PROVIDER.

_____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN

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.

SECTION 5 - MAILING INSTRUCTIONS

PLEASE ATTACH ALL ORIGINAL CORRESPONDENCE and retain copies for your files as original receipts will not be returned. 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.**

CUSTOMER SERVICE CENTRE 1-888-711-1119 or (519) 739-1133

PLEASE INDICATE ON MAILING ENVELOPE: **GREEN SHIELD CANADA P.O. BOX 1615, WINDSOR, ON N9A 7J3** ATTENTION: **VISION DEPARTMENT** **greenshield.ca**