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

Subscriber Name _____ **Date of Birth** _____/_____/_____ **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/SUBSCRIBER.

By signing this claim form and/or submitting actual receipts, 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 about myself and my dependants, 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 am authorized by my spouse and/or dependants to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.

All claims must be submitted within 12 months of the date of service.