



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
SURNAME	FIRST NAME
DATE OF BIRTH (YY/MM/DD)	
ADDRESS	
CITY	PROVINCE
POSTAL CODE	

PROVIDER INFORMATION

PROVIDER NUMBER	PROVIDER PHONE #
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 3 a – EYE EXAM CLAIM DETAILS (ONLY IF INCLUDED WITH THIS SUBMISSION)

EYE EXAM	PROVIDER NUMBER	OPTOMETRIST NAME, ADDRESS & PHONE NUMBER
YEAR MONTH DAY		
AMOUNT \$	PAY PLAN MEMBER <input type="checkbox"/>	
	PAY PROVIDER <input type="checkbox"/>	

SECTION 3b – EYEWEAR CLAIM DETAILS

CHARGES		DATE EYEWEAR RECEIVED OR PAID IN FULL: _____				MUST BE COMPLETED IN ALL CASES BY SUPPLIER:
		YEAR	MONTH	DAY		
FRAMES		SPHERE	CYLINDER	AXIS	PRISM	<input type="checkbox"/> New Prescription <input type="checkbox"/> Safety Glasses <input type="checkbox"/> Lenses Only <input type="checkbox"/> Post Cataract claim
EYEGLOSS LENSES		R				
CONTACT LENSES		L				
DISPENSING FEE		BIFOCAL	PROGRESSIVE BIFOCAL	TRIFOCAL	TINT	
MISC./DIAGNOSTIC TEST					Colour & No	If Post Cataract claim, does patient have lens implant? <input type="checkbox"/> Yes <input type="checkbox"/> No
1. _____		R	R	R		
2. _____		L	L	L		
TOTAL						
PATIENT PAID		CONTACT LENSES:				
		Can visual acuity be restored to at least 20/70 in the better eye with conventional eye glasses?				<input type="checkbox"/> Yes <input type="checkbox"/> No
BALANCE TO PROVIDER		Can visual acuity be restored to at least 20/40 in the better eye with conventional eye glasses?				<input type="checkbox"/> Yes <input type="checkbox"/> No
		Are they medically necessary due to keratoconus, irregular astigmatism or irregular corneal curvature?				<input type="checkbox"/> Yes <input type="checkbox"/> 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 _____

By signing this claim form and/or submitting original 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 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 authorize the release of the information contained on this form. 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.

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