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.

SECTION 1 – PATIENT INFORMATION

GREEN SHIELD ID NUMBER	COMPANY NAME	DATE OF BIRTH (YY/MM/DD)
SURNAME / FIRST NAME		
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 – CLAIM DETAILS

TREATMENT RENDERED	CHARGES
EYE EXAM Date: (y/m/d) _____	
OTHER DIAGNOSTIC: _____	
FRAME	
EYEGLASS LENSES	
CONTACT LENSES	
FEE	
MISC 1. _____ (Photogrey, oversize) 2. _____	
TOTAL	
PATIENT PAID	
BALANCE TO PROVIDER	

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

☐ **OPTOMETRIST**
☐ **OPTICIAN**

NAME AND ADDRESS

_____
_____
_____

	SPHERE	CYLINDER	AXIS	PRISM	TINT
	R				Colour & No
	L				1 2

	BIFOCAL	PROGRESSIVE BIFOCAL	TRIFOCAL
R			
L			

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

DATE OF PICK UP: _____ (YEAR) _____ (MONTH) _____ (DAY)

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 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 authorize the release of the information contained on this form. 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.

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.

PLEASE INDICATE ON MAILING ENVELOPE:

GREEN SHIELD CANADA
P.O. BOX 1615, WINDSOR, ON N9A 7J3
ATTENTION: VISION DEPARTMENT

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