SAMPLE OF A RECEIPT FOR PLAN MEMBER

gsc green shield canada

CLAIM FORM FOR GOVERNMENT HEALTH INSURANCE REPLACEMENT COVERAGE (VS PLAN)

Green Shield Canada Travel Assistance, Allianz Global Assistance
4273 King St. East, Kitchener, ON N2P 2E9 For claim inquiries: 1-800-363-1835

HOW TO CLAIM

Physician Services: Complete sections 1, 2 and 7 of this form and forward it to the address above.
Hospital Services: **Complete sections 1, 3 and 7 of this form and forward it with *itemized statements* to the address above.**
Commercial Lab: Complete sections 1, 4 and 7 of this form and forward it to the address above.
Ambulance Services: Complete sections 1, 5 and 7 of this form and forward it to the address above.
Other Services: Complete sections 1, 6 and 7 of this form and forward it to the address above.

* ONE CLAIM FORM PER PROVIDER

SECTION 1 PATIENT AND PROVIDER INFORMATION

Patient Information

Name JOHN DOE Date of Birth Jan. 1/99
Address 1234 Riverside Dr. Apt # 101
Windsor, ON N9B 3P4
Green Shield Identification Number 8881234 - 00
Group Name 6696-100 use this #

Provider Information Provider No. ———

Name DYNACARE
Address 115 MIDAIR CRT.
Brampton, ON L6T 5M3
Telephone Number 1-800-668-2714
Physician ☐ Hospital ☐ Commercial Lab ☒
Ambulance ☐ Other (Please Specify)

SECTION 2 PHYSICIAN FEES (office, home, institution or hospital services)

Description of Treatment Rendered	Diagnosis Code	Assessment Code	Date of Treatment (Yr Mo Dy)	Total Charge

SECTION 3 HOSPITAL SERVICES (A - inpatient charges, B - outpatient/emergency charges)

	Admission Date (Yr Mo Dy)	Discharge Date (Yr Mo Dy)	Diagnosis Code	Room Type (Active/acute, Chronic, Rehab)	Rate per day	No of days	Total Charge
A							

	Description of Treatment Rendered	Diagnosis Code	Date of Treatment (Yr Mo Dy)	Total Charge
B				

SECTION 4 COMMERCIAL LAB/X-RAYS

Description of Treatment Rendered	Service Code	Date of Treatment (Yr Mo Dy)	Total Charge
Glucose Testing	L111A	2017/09/30	$19.66
Urine Culture	L634A	2017/09/30	$10.34

SECTION 5 AMBULANCE SERVICES

Reason for ambulance trip	Date of Service	Ambulance taken From	Ambulance taken To	Total Charge

SECTION 6 OTHER SERVICES

Description of Treatment Rendered	Date of Treatment (Yr Mo Dy)	Total Charge

SECTION 7 AUTHORIZATION AND DIRECTION

Were the above services required as a result of a motor vehicle accident? Yes ___ No X
Were the above services required as a result of a work related accident? Yes ___ No X

I certify that the treatment described above was performed and all information provided on this form is accurate.	The charges listed on this claim have been paid in full by the plan member. Please reimburse the plan member directly.	I certify that the above treatment was rendered and hereby authorize payment for eligible services directly to the provider named above
Signature of Provider Designation/Registration #	Signature of Provider	Signature of Patient/Guardian

John Doe

sign here if you Paid

By signing this claim form and/or submitting actual receipts, I agree that [illegible] this claim 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.

THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/PLAN MEMBER.
ALL CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS OF THE DATE OF SERVICE (unless otherwise stated in your benefit plan documentation).

SAMPLE OF AN INVOICE FOR A DEPENDANT

gsc green shield canada

CLAIM FORM FOR GOVERNMENT HEALTH INSURANCE REPLACEMENT COVERAGE (VS PLAN)

Green Shield Canada Travel Assistance, Allianz Global Assistance
4273 King St. East, Kitchener, ON N2P 2E9 For claim inquiries: 1-800-363-1835

HOW TO CLAIM

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Ambulance Services: Complete sections 1, 5 and 7 of this form and forward it to the address above.
Other Services: Complete sections 1, 6 and 7 of this form and forward it to the address above.

* ONE CLAIM FORM PER PROVIDER

SECTION 1 PATIENT AND PROVIDER INFORMATION

Patient Information

Name: JOEY DOE Date of Birth: Dec 12/12
Address: 1234 Riverside Dr. Apt #101
Windsor, ON N9B 3P4
Green Shield Identification Number: 8881234-02
Group Name: 66696-100 use this #

Provider Information Provider No.

Name: DR. BRIAN NHAN
Address: 2462 Howard Ave Suite #134
Windsor, ON N8X 3V6
Telephone Number: 519-946-3303
Physician ☒ Hospital ☐ Commercial Lab ☐
Ambulance ☐ Other (Please Specify)

SECTION 2 PHYSICIAN FEES (office, home, institution or hospital services)

Description of Treatment Rendered	Diagnosis Code	Assessment Code	Date of Treatment (Yr Mo Dy)	Total Charge
Dr. Consult			2017/10/31	$80.00

SECTION 3 HOSPITAL SERVICES (A - inpatient charges, B - outpatient/emergency charges)

	Admission Date (Yr Mo Dy)	Discharge Date (Yr Mo Dy)	Diagnosis Code	Room Type (Active/acute, Chronic, Rehab)	Rate per day	No of days	Total Charge
A							

	Description of Treatment Rendered	Diagnosis Code	Date of Treatment (Yr Mo Dy)	Total Charge
B				

SECTION 4 COMMERCIAL LAB/X-RAYS

Description of Treatment Rendered	Service Code	Date of Treatment (Yr Mo Dy)	Total Charge

SECTION 5 AMBULANCE SERVICES

Reason for ambulance trip	Date of Service	Ambulance taken From	Ambulance taken To	Total Charge

SECTION 6 OTHER SERVICES

Description of Treatment Rendered	Date of Treatment (Yr Mo Dy)	Total Charge

SECTION 7 AUTHORIZATION AND DIRECTION

Were the above services required as a result of a motor vehicle accident? Yes ___ No X
Were the above services required as a result of a work related accident? Yes ___ No X

I certify that the treatment described above was performed and all information provided on this form is accurate.	The charges listed on this claim have been paid in full by the plan member. Please reimburse the plan member directly.	I certify that the above treatment was rendered and hereby authorize payment for eligible services directly to the provider named above
Signature of Provider Designation/Registration #	Signature of Provider	Signature of Patient/Guardian: John Doe

Sign here if you didn't pay

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 may be given to Green Shield Canada about myself and my dependants, will be used by Green Shield Canada for claims adjudication and any other services necessary to the administration of 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 information may be released only by the cardholder.

THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/PLAN MEMBER.
ALL CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS OF THE DATE OF SERVICE (unless otherwise stated in your benefit plan documentation).