SAMPLE OF AN RECEIPT FOR A DEPENDANT

HOW TO CLAIM:

Physician Fees:	Complete sections 1, 2, and 8 of this form.
Hospital Services:	Complete sections 1, 3, and 8 of this form.
Commercial Lab/X-Rays:	Complete sections 1, 4, and 8 of this form.
Ambulance Services:	Complete sections 1, 5, and 8 of this form.
Other Services:	Complete sections 1, 6, and 8 of this form.

***ONE FORM PER SERVICE PROVIDER**

NO STAPLES PLEASE, PAPER CLIPS ONLY

gsc green shield canada

PROVINCIAL REPLACEMENT PLAN CLAIM FORM

Please use one form per practitioner, per patient

This form is to be used for Visitors to Canada and International Students.

- Fill in Green Shield number here.
- Fill in patient's birthdate.
- Patient's last name and first name.
- Patient's address.
- Your email.

- Leave provider's number blank.
- Fill in providers phone number.
- Provider name (if seeing a doctor) or clinic name (if going for x-ray, labs, etc).
- Address of location.
- Leave provider's email blank.
- Check appropriate box for the service received.

SECTION 1 - PATIENT INFORMATION

GREEN SHIELD NUMBER: 8881234-03	DATE OF BIRTH (YY/MM/DD): 19 / 12 / 31
SURNAME: Doe	FIRST NAME: Jill
ADDRESS: 1234 Riverside Drive Apt #101	
CITY: Windsor	PROVINCE: ON — POSTAL CODE: N9B3P4
EMAIL: johndoe@uwindsor.ca	

PROVIDER INFORMATION

PROVIDER NUMBER: ----	PROVIDER PHONE #: (519) 254-7553
PROVIDER NAME: ECR Clinic (X-Ray Associates)	
ADDRESS: 2224 Walker Rd Suite #160	
CITY: Windsor	PROVINCE: ON — POSTAL CODE: N8W5L7
EMAIL: ----	

PHYSICIAN ☐ HOSPITAL ☐ AMBULANCE ☒
COMMERCIAL LAB ☒ OTHER (PLEASE SPECIFY) _____

SECTION 2 - PHYSICIAN FEES (OFFICE, HOME, INSTITUTION OR HOSPITAL SERVICES)

DESCRIPTION OF TREATMENT RENDERED	DIAGNOSIS CODE	ASSESSMENT CODE	DATE OF TREATMENT YY	MM	DD	CHARGES ($)

SECTION 3 – HOSPITAL SERVICES

INPATIENT CHARGES		OUTPATIENT / EMERGENCY CHARGES	
ADMISSION DATE (YY/MM/DD):	_____ / _____ / _____	DESCRIPTION OF TREATMENT RENDERED:	
DISCHARGE DATE (YY/MM/DD):	_____ / _____ / _____		
DIAGNOSIS CODE:			
ROOM TYPE: (ACTIVE / ACUTE, CHRONIC, REHAB)			
DAILY RATE:		DIAGNOSIS CODE:	
NO. OF DAYS:		DATE OF TREATMENT (YY/MM/DD):	_____ / _____ / _____
TOTAL CHARGE:	$	TOTAL CHARGE:	$

- Since this example is for an x-ray, section 4 is filled out.
- Brief description of service received (ex. Pelvic ultrasound)
- Fill in service code **(FOUND ON RECEIPT)** - if you cannot find this, **contact lab.**
- Fill out the date of visit.
- Fill out amount that was paid.

SECTION 4 - COMMERCIAL LAB / X-RAYS

DESCRIPTION OF TREATMENT RENDERED	SERVICE CODE	DATE OF TREATMENT YY	MM	DD	CHARGES ($)
U/S Complete Pelvis	J162	25	01	02	$150.00

SECTION 5 - AMBULANCE SERVICES

REASON FOR AMBULANCE TRIP	DATE OF SERVICE YY	MM		AMBULANCE TAKEN FROM	AMBULANCE TAKEN TO	CHARGES ($)

SECTION 6 - OTHER SERVICES

DESCRIPTION OF TREATMENT RENDERED	DATE OF TREATMENT	MM		CHARGES ($)

- **Student who is the primary member** - sign your name down at the bottom, along with the current date.

I certify that the treatment described above was performed and all information provided on this form is accurate.

I CONFIRM THAT ALL INFORMATION CONTAINED ON THIS FORM IS TRUE AND ACCURATE.

John Doe — SIGNATURE OF PROVIDER

DESIGNATION/REGISTRATION #

2025/02/01 — DATE

PRP_EN

NO STAPLES PLEASE, PAPER CLIPS ONLY

SECTION 7 - AUTHORIZATION AND CONSENT

At Green Shield Canada ("**GSC**," "**we**," "**us**" or "**our**"), respecting and protecting the privacy and confidentiality of your personal information is a priority. In order to provide you with the services for which we have been engaged, we need you to understand, and consent to, a few things. We may collect/receive from you or other parties and use, share, disclose and process your personal information and, if applicable, that of your spouse, children and other dependents (collectively, "**you**" or "**your**"), which may include name, age, claims history, income, email address, service providers that may have been used and banking information. We may do this for various purposes related to the administration of your benefits plan and to provide you other products and services, including but not limited to: benefits coordination with other carriers; administration and adjudication of claims; auditing, investigating, and taking steps connected to the prevention or suppression of suspected or proven improper or fraudulent claims; identity checks; billing and collection of premiums; medical underwriting; communication with other service providers, communication with third parties to confirm the accuracy of claims, provide contracted services, or for health management purposes or programs; collecting information about services that are provided, analyzing data, including information on how you use our products and services, to help us make informed decisions and improve the products and services we offer; determining if there are other products and services that you might be interested in, and sending you details about them; compliance with applicable laws and regulations; and such other activities that a reasonable person would consider associated with the administration of your benefit plan. In carrying-out these purposes, we may collect, receive, share or disclose your personal information with others outside of GSC, including, but not limited to: your employer, sponsor(s) of your benefit plan, and insurance advisors, if your benefits are provided through your employer's group benefits plan; benefits providers (e.g. pharmacists, massage therapists); professional regulatory bodies (e.g. College of Pharmacists); government agencies; applicable law enforcement bodies (local, provincial and federal); industry drug pooling entities (e.g. Canadian Drug Insurance Pooling Corporation); GSC's third party service providers who assist us in administering your benefits plan and providing you with other related products and services and such other third parties as may be appropriate or reasonably necessary in carrying out the purposes set out above. Although sharing of personal information is inherently risky, we implement commercially-acceptable procedures to secure and protect your personal information using appropriate technological, physical and organizational measures designed to protect personal information. In the event of an unauthorized release by us of your personal information, we will notify you in accordance with applicable privacy laws. More information about our privacy practices is available in our Privacy Policy at www.greenshield.ca, which is a necessary and integral part of this privacy consent. We may from time to time revise our Privacy Policy to reflect changes in, for example, legislation or regulation, or as we introduce new features, products or services. The most current version of the policy will govern how we process your personal data and will always be available on www.greenshield.ca. You can contact our Privacy Officer at privacy.office@greenshield.ca if you have a question or complaint.

By signing below, you are providing your consent to GSC's collection, use and disclosure of your personal information as explained above, and you are acknowledging that you are authorized by your spouse, children and other dependents (if applicable) to disclose and receive their personal information, and to provide this privacy consent on their behalf. You agree that a photocopy, facsimile or electronic version of this consent will be as valid as the original. You can withdraw your consent at any time by providing notice in writing to GSC at privacy.office@greenshield.ca, but, if you do so, GSC will no longer be able to administer your benefits plan and process your claims.

Name _____ **Signature** _____ **Date** _____

SECTION 8 - ASSIGNMENT OF BENEFITS

I HEREBY ASSIGN PAYMENT DIRECTLY TO THE PROVIDER.

DO NOT SIGN THIS BOX IF YOU HAVE A RECEIPT AND HAVE PAID FOR THE SERVICE.

_____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

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

John Doe

_____

SIGNATURE OF PROVIDER

VERY IMPORTANT

- You can sign the **RIGHT** box of section 8 if you have paid for the service and have a receipt. This means **THE STUDENT** will be refunded with the payment. You do not need a provider signature.

SECTION 9 - CLAIM SUBMISSION INSTRUCTIONS

ALL CLAIMS MUST BE RECEIVED WITHIN 12 MONTHS OF THE DATE OF SERVICE (unless otherwise stated in your benefit plan documentation).
PLEASE ATTACH ALL ORIGINAL CORRESPONDENCE and retain copies for your files as original receipts will not be returned.
The cost, if any, of obtaining this information is at the expense of the Patient/Plan Member.

GREENSHIELD
8677 ANCHOR DRIVE
P.O. BOX 1606
WINDSOR, ON
N9A 6W1
CUSTOMER SERVICE CENTRE

The attachment tool within your **Plan Member Online Services** or **providerConnect** account allows you to upload documentation to avoid having to send such documentation through the mail.

1-888-711-1119 or (519) 739-1133 **greenshield.ca**

***Submit documents via Canada Post OR customer.service@greenshield.ca**

PRP_EN

SAMPLE OF AN INVOICE FOR A DEPENDANT

HOW TO CLAIM:

Physician Fees:	Complete sections 1, 2, and 8 of this form.
Hospital Services:	Complete sections 1, 3, and 8 of this form.
Commercial Lab/X-Rays:	Complete sections 1, 4, and 8 of this form.
Ambulance Services:	Complete sections 1, 5, and 8 of this form.
Other Services:	Complete sections 1, 6, and 8 of this form.

***ONE FORM PER SERVICE PROVIDER**

NO STAPLES PLEASE, PAPER CLIPS ONLY

gsc green shield canada

PROVINCIAL REPLACEMENT PLAN CLAIM FORM

Please use one form per practitioner, per patient

This form is to be used for Visitors to Canada and International Students.

- Fill in Green Shield number here.
- Fill in patient's birthdate.
- Patient's last name and first name.
- Patient's address.
- Your email.

- Leave provider's number blank.
- Fill in providers phone number.
- Provider name (if seeing a doctor) or clinic name (if going for x-ray, labs, etc).
- Address of location.
- Leave provider's email blank.
- Check appropriate box for the service received.

- Since this example is for a doctor visit, section 2 is filled out.
- Brief description of service received (ex. Dr. consult.)
- Fill in assessment code **(FOUND ON INVOICE)** - if you cannot find this, **contact doctor office.**
- Fill out the date of visit.
- Fill out outstanding balance owing to doctor office.

- **Student who is the primary member** - sign your name down at the bottom, along with the current date.

SECTION 1 - PATIENT INFORMATION

GREEN SHIELD NUMBER: 8881234-02	DATE OF BIRTH (YY/MM/DD): 19 / 12 / 31
SURNAME: Doe	FIRST NAME: Joey
ADDRESS: 1234 Riverside Drive Apt #101	
CITY: Windsor	PROVINCE: ON — POSTAL CODE: N9B3P4
EMAIL: johndoe@uwindsor.ca	

PROVIDER INFORMATION

PROVIDER NUMBER: ----	PROVIDER PHONE #: (519) 946-3303
PROVIDER NAME: Dr. Brian Nhan	
ADDRESS: 2462 Howard Ave Suite #134	
CITY: Windsor	PROVINCE: ON — POSTAL CODE: N8X3V6
EMAIL: ---	

PHYSICIAN ☒ HOSPITAL ☐ AMBULANCE ☒
COMMERCIAL LAB ☐ OTHER (PLEASE SPECIFY) _____

SECTION 2 - PHYSICIAN FEES (OFFICE, HOME, INSTITUTION OR HOSPITAL SERVICES)

DESCRIPTION OF TREATMENT RENDERED	DIAGNOSIS CODE	ASSESSMENT CODE	DATE OF TREATMENT YY	MM	DD	CHARGES ($)
Doctor Consultation		1026A	25	1	2	$ 100.00

SECTION 3 – HOSPITAL SERVICES

INPATIENT CHARGES		OUTPATIENT / EMERGENCY CHARGES	
ADMISSION DATE (YY/MM/DD):	____/____/____	DESCRIPTION OF TREATMENT RENDERED:	
DISCHARGE DATE (YY/MM/DD):	____/____/____		
DIAGNOSIS CODE:			
ROOM TYPE: (ACTIVE / ACUTE, CHRONIC, REHAB)			
DAILY RATE:		DIAGNOSIS CODE:	
NO. OF DAYS:		DATE OF TREATMENT (YY/MM/DD):	____/____/____
TOTAL CHARGE:	$	TOTAL CHARGE:	$

SECTION 4 - COMMERCIAL LAB / X-RAYS

DESCRIPTION OF TREATMENT RENDERED	SERVICE CODE	DATE OF TREATMENT YY	MM	DD	CHARGES ($)

SECTION 5 - AMBULANCE SERVICES

REASON FOR AMBULANCE TRIP	DATE OF SERVICE YY	MM	DD	AMBULANCE TAKEN FROM	AMBULANCE TAKEN TO	CHARGES ($)

SECTION 6 - OTHER SERVICES

DESCRIPTION OF TREATMENT RENDERED	DATE OF TREATMENT YY	MM	DD	CHARGES ($)

I certify that the treatment described above was performed and all information provided on this form is accurate.

I CONFIRM THAT ALL INFORMATION CONTAINED ON THIS FORM IS TRUE AND ACCURATE.

John Doe — **SIGNATURE OF PROVIDER**

DESIGNATION/REGISTRATION #

2025/02/01 — **DATE**

PRP_EN

NO STAPLES PLEASE, PAPER CLIPS ONLY

SECTION 7 - AUTHORIZATION AND CONSENT

At Green Shield Canada ("**GSC**," "**we**," "**us**" or "**our**"), respecting and protecting the privacy and confidentiality of your personal information is a priority. In order to provide you with the services for which we have been engaged, we need you to understand, and consent to, a few things. We may collect/receive from you or other parties and use, share, disclose and process your personal information and, if applicable, that of your spouse, children and other dependents (collectively, "**you**" or "**your**"), which may include name, age, claims history, income, email address, service providers that may have been used and banking information. We may do this for various purposes related to the administration of your benefits plan and to provide you other products and services, including but not limited to: benefits coordination with other carriers; administration and adjudication of claims; auditing, investigating, and taking steps connected to the prevention or suppression of suspected or proven improper or fraudulent claims; identity checks; billing and collection of premiums; medical underwriting; communication with other service providers, communication with third parties to confirm the accuracy of claims, provide contracted services, or for health management purposes or programs; collecting information about services that are provided, analyzing data, including information on how you use our products and services, to help us make informed decisions and improve the products and services we offer; determining if there are other products and services that you might be interested in, and sending you details about them; compliance with applicable laws and regulations; and such other activities that a reasonable person would consider associated with the administration of your benefit plan. In carrying-out these purposes, we may collect, receive, share or disclose your personal information with others outside of GSC, including, but not limited to: your employer, sponsor(s) of your benefit plan, and insurance advisors, if your benefits are provided through your employer's group benefits plan; benefits providers (e.g. pharmacists, massage therapists); professional regulatory bodies (e.g. College of Pharmacists); government agencies; applicable law enforcement bodies (local, provincial and federal); industry drug pooling entities (e.g. Canadian Drug Insurance Pooling Corporation); GSC's third party service providers who assist us in administering your benefits plan and providing you with other related products and services and such other third parties as may be appropriate or reasonably necessary in carrying out the purposes set out above. Although sharing of personal information is inherently risky, we implement commercially-acceptable procedures to secure and protect your personal information using appropriate technological, physical and organizational measures designed to protect personal information. In the event of an unauthorized release by us of your personal information, we will notify you in accordance with applicable privacy laws. More information about our privacy practices is available in our Privacy Policy at www.greenshield.ca, which is a necessary and integral part of this privacy consent. We may from time to time revise our Privacy Policy to reflect changes in, for example, legislation or regulation, or as we introduce new features, products or services. The most current version of the policy will govern how we process your personal data and will always be available on www.greenshield.ca. You can contact our Privacy Officer at privacy.office@greenshield.ca if you have a question or complaint.

By signing below, you are providing your consent to GSC's collection, use and disclosure of your personal information as explained above, and you are acknowledging that you are authorized by your spouse, children and other dependents (if applicable) to disclose and receive their personal information, and to provide this privacy consent on their behalf. You agree that a photocopy, facsimile or electronic version of this consent will be as valid as the original. You can withdraw your consent at any time by providing notice in writing to GSC at privacy.office@greenshield.ca, but, if you do so, GSC will no longer be able to administer your benefits plan and process your claims.

Name **Signature** **Date**

SECTION 8 - ASSIGNMENT OF BENEFITS

I HEREBY ASSIGN PAYMENT DIRECTLY TO THE PROVIDER.

John Doe

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

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

DO NOT SIGN THIS BOX IF YOU HAVE AN INVOICE AND HAVE NOT PAID FOR THE SERVICE.

SIGNATURE OF PROVIDER

VERY IMPORTANT

- You can sign the **LEFT** box of section 8 if you have an invoice and did not pay. This means **THE PROVIDER** will be refunded with the payment. You do not need a provider signature.

SECTION 9 - CLAIM SUBMISSION INSTRUCTIONS

ALL CLAIMS MUST BE RECEIVED WITHIN 12 MONTHS OF THE DATE OF SERVICE (unless otherwise stated in your benefit plan documentation).
PLEASE ATTACH ALL ORIGINAL CORRESPONDENCE and retain copies for your files as original receipts will not be returned.
The cost, if any, of obtaining this information is at the expense of the Patient/Plan Member.

GREENSHIELD
8677 ANCHOR DRIVE
P.O. BOX 1606
WINDSOR, ON
N9A 6W1

CUSTOMER SERVICE CENTRE

The attachment tool within your **Plan Member Online Services** or **providerConnect** account allows you to upload documentation to avoid having to send such documentation through the mail.

1-888-711-1119 or (519) 739-1133 **greenshield.ca**

***Submit documents via Canada Post OR customer.service@greenshield.ca**

PRP_EN