NO STAPLES PLEASE, PAPER CLIPS ONLY

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.

SECTION 1 - PATIENT INFORMATION

GREEN SHIELD NUMBER	DATE OF BIRTH (YY/MM/DD)
	____/____/____

SURNAME	FIRST NAME

ADDRESS		
CITY	PROVINCE	POSTAL CODE

EMAIL

PROVIDER INFORMATION

PROVIDER NUMBER	PROVIDER PHONE #

PROVIDER NAME

ADDRESS		
CITY	PROVINCE	POSTAL CODE

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

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

OUTPATIENT / EMERGENCY CHARGES

DESCRIPTION OF TREATMENT RENDERED:	
DIAGNOSIS CODE:	
DATE OF TREATMENT (YY/MM/DD):	____/____/____
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.

SIGNATURE OF PROVIDER	DESIGNATION/REGISTRATION #	DATE

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.	THE CHARGES LISTED ON THIS CLAIM HAVE BEEN PAID IN FULL BY THE PATIENT. PLEASE REIMBURSE PATIENT DIRECTLY.
SIGNATURE OF PATIENT OR LEGAL GUARDIAN	SIGNATURE OF PROVIDER

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

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.

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