

For claims requiring pre-authorization or specific claim forms,  
please request from our **CUSTOMER SERVICE CENTRE**  
1-888-711-1119

**EHS CLAIM SUBMISSION FORM (required for timely processing of claims)**

**A. SUBSCRIBER INFORMATION**

Subscriber Surname \_\_\_\_\_ **Green Shield I.D. #** \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Home Telephone # \_\_\_\_\_ Work Telephone # \_\_\_\_\_ E-mail Address \_\_\_\_\_ Name of Employer \_\_\_\_\_

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**B. PATIENT INFORMATION (Only include names of patients with receipts attached.)**

First Name	Last Name	Dependant #	Date of Birth
			yr / mm / dd
			yr / mm / dd
			yr / mm / dd

**C. MANDATORY DECLARATION**

1. Are any of the expenses being claimed covered by another group insurance plan?  No  Yes. If yes, complete the following information about the person who is the MEMBER under the other plan: (If claiming coordination of benefits, please provide alternate carrier's explanation of benefits)

Other Member's Name \_\_\_\_\_

If other coverage is Green Shield, indicate Green Shield Identification No.: \_\_\_\_\_

2. Are any of the expenses being claimed due to:

A. A work related injury?  No  Yes If yes, date of injury 

yr	mm	dd
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B. A motor vehicle accident?  No  Yes If yes, date of accident 

yr	mm	dd
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**D. CLAIMS (All claims must be submitted within 12 months of the date of service.)**

Patient's First Name	Dep #	Professional's/ Supplier's Name & Provider # (if available)	Date of Claim (yr/mm/dd)	Type of Expense	Total Amount Charged Per Visit/Item

**E. AUTHORIZATION**

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 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.

Subscriber's Signature 

X
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 Date 

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**F. MAILING INSTRUCTIONS**

Please indicate on mailing envelope: Attention:

Professional Services P.O. Box 1699 Windsor, ON N9A 7G6	Medical Items P.O. Box 1623 Windsor, ON N9A 7B3	Out-of Country Dept. & HCSA P.O. Box 1606 Windsor, ON N9A 6W1	Vision & Accommodation P.O. Box 1615 Windsor, ON N9A 7J3
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**PLEASE ATTACH ALL ORIGINAL PAID RECEIPTS, PRESCRIPTIONS AND AUTHORIZATION FORMS**  
Please retain copies for your files as original receipts will not be returned