

For claims requiring completion, request forms from our  
**CUSTOMER SERVICE CENTRE**  
1-888-711-1119

## DRUG CLAIM SUBMISSION FORM

### A. SUBSCRIBER INFORMATION

Subscriber Surname _____		<b>Green Shield I.D. #</b> _____	
Street Address _____		City _____	Province _____ Postal Code _____
Home Telephone # ( ) _____	Work Telephone # ( ) _____	E-mail Address _____	Name of Employer _____

### B. 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 with receipt copies).**

Other Member's Name \_\_\_\_\_  
(in full)

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 

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(yr/mm/dd)

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

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### C. CLAIMANT (Only include names of patients with receipts attached.)

Patient's First Name	Dep#	Date of Birth (yr/mm/dd)	Pharmacy Name	Location	Phone #

### D. TO FACILITATE CLAIM PROCESSING

- ◆ If claim is from **out of country**, please provide:
  - Name of country visited \_\_\_\_\_
  - Currency Used \_\_\_\_\_
- ◆ Please note, cash register receipts & credit card/debit slips are insufficient. Please contact your pharmacy for duplicate receipts.
- ◆ Original receipts must contain claimant's name, date of service, drug name and Drug Identification Number (DIN).
- ◆ Manual submission of this claim may not be required. Please check with your pharmacist regarding on-line claim submission.

### E. AUTHORIZATION

By signing this claim form and/or submitting actual receipts, I agree that the information provided is complete and accurate, to the best of my knowledge. I authorize Green Shield Canada to exchange information with other parties as required and only when the information is needed to administer this benefit claim and/or to confirm the accuracy of this information.

Subscriber's Signature X Date 

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### F. Mailing Instructions

**Please mail to the attention of :    Drug Dept.**  
**P.O. Box 1652, Windsor, Ontario N9A 7G5**

**PLEASE ATTACH ALL ORIGINAL PAID RECEIPTS**  
**Please retain copies for your files as original receipts will not be returned**

**The intentional falsification, misrepresentation or omission of information on or relating to this claim constitutes fraud.**