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.

SECTION 1 PATIENT AND PROVIDER INFORMATION

Patient Information

Name _____ Date of Birth _____

Address _____

Green Shield Identification Number _____

Group Name _____

Provider Information Provider No. _____

Name _____

Address _____

Telephone Number _____

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

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 ☐

Were the above services required as a result of a work related accident? Yes ☐ No ☐

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**

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 dependents, 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 dependents 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).