GREEN SHIELD CANADA

VISION CARE CLAIM FORM

PROVIDER IDENTIFICATION

Date of Pick Up

Provider No. | Year | Month | Day

Name

Optometrist ☐

Optician ☐

Address

City/Town | Prov. | Postal Code

Signature | Telephone No. ( )

PATIENT

Green Shield No.

Surname | Given Name

Address | Apt.

City | Prov. | Postal Code

Relationship to Subscriber | Date of Birth ____/____/____ Yr Mo Day

Employer's Name: | Telephone No. ( )

Do you have other Vision Care Coverage? Yes ☐ No ☐

If Yes, Please Complete Policy No. _____

Name of Insurer or Plan _____

If Yes, either a copy of the payment statement or denial letter from the primary carrier must be attached.

Is this a W.S.I.B. claim? Yes ☐ No ☐

Subscriber's Date of Birth Yr Mo Day

Spouse's Date of Birth Yr Mo Day

Must Be Completed By Supplier in All Cases

New Prescription ☐ Yes | Lenses Only ☐ Yes

Safety Glasses ☐ Yes | Post-Cataract Claim ☐ Yes

If yes for post-cataract, does patient have a lens implant? Yes ☐ No ☐

Prescription Details

	Sphere	Cylinder	Axis	Prism	Tint
R					(Colour & No.) 1 2
L					

Add Bifocal	Type of Bifocal	Add Trifocal	Type of Trifocal
R		R	
L		L	

CONTACT LENSES:

A) CAN VISUAL ACUITY BE RESTORED TO AT LEAST 20/70 IN THE BETTER EYE WITH CONVENTIONAL EYE GLASSES? ☐ Yes ☐ No

B) CAN VISUAL ACUITY BE RESTORED TO AT LEAST 20/40 IN THE BETTER EYE WITH CONVENTIONAL EYE GLASSES? ☐ Yes ☐ No

C) ARE THEY MEDICALLY NECESSARY DUE TO KERATOCONUS, IRREGULAR ASTIGMATISM OR IRREGULAR CORNEAL CURVATURE? ☐ Yes ☐ No

(THERE IS NO NEED TO ATTACH A RECEIPT IF THIS FORM HAS BEEN COMPLETED AND IF THIS AREA HAS BEEN SIGNED.)

THE CHARGES LISTED ON THIS CLAIM HAVE BEEN PAID IN FULL BY THE SUBSCRIBER. PLEASE PAY SUBSCRIBER FOR ELIGIBLE CHARGES.

SIGNATURE OF SUPPLIER _____

I UNDERSTAND THAT THE CHARGES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY AGREEMENT BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO MY SUPPLIER FOR THE COST OF THOSE SERVICES. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS FORM.

_____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN

(ONLY COMPLETE THIS SECTION ON THE DATE OF PICKUP, AND ONLY IF THIS FORM IS COMPLETED.) I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE ABOVE NAMED SUPPLIER AND AUTHORIZE PAYMENT DIRECTLY TO THE SUPPLIER.

_____

SIGNATURE OF SUBSCRIBER

Frame and Manufacturer

Eye Size

☐ Plastic ☐ Heat Hardened ☐ Chemically Hardened

BREAKDOWN OF EXTRA CHARGES: (EG. OVERSIZE, PHOTOGREY, CASE, ETC.) TRANSFER ITEMS TO MISC. BELOW

MISCELLANEOUS	AMOUNT
1.	$
2.	$
3.	$

TOTAL $

Actual Charges		Green Shield Only
Frame		
Eyeglass Lenses		
Fee		
Contact Lenses		
Misc. 1		
Misc. 2		
Misc. 3		
Eye Exam		
Total		
Patient Paid		
Balance to be Paid to Supplier		

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.

GREEN SHIELD CANADA - **ATTENTION: VISION DEPARTMENT**
P.O. BOX 1615, WINDSOR, ONTARIO N9A 7J3 - **CUSTOMER SERVICE CENTRE 1-888-711-1119 or (519) 739-1133**

THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/SUBSCRIBER.
ALL CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS OF THE DATE OF SERVICE.