CLAIM FORM FOR IN HOME SUPPORT SERVICES OF AN RN, RNA, RPN, PNA, LPN, PERSONAL SUPPORT WORKER

GREEN SHIELD NO.	**PROVIDER NO.**
PATIENT NAME **INITIAL**	**NURSING REGISTRY**
ADDRESS	**ADDRESS** **CITY** **PROVINCE**
CITY **PROVINCE** **POSTAL CODE**	**POSTAL CODE** **TELEPHONE NO.**

DO YOU HAVE ANY OTHER GROUP INSURANCE COVERAGE THAT MAY INCLUDE THESE SERVICES AS BENEFITS? YES ☐ NO ☐
IF YES, INSURANCE COMPANY NAME _____
IF OTHER COVERAGE IS GREEN SHIELD, INDICATE GREEN SHIELD NUMBER: _____
IS TREATMENT REQUIRED DUE TO A MOTOR VEHICLE ACCIDENT? YES ☐ NO ☐ DATE OF ACCIDENT: _____
IS TREATMENT REQUIRED DUE TO A WORK RELATED INJURY? YES ☐ NO ☐
IS TREATMENT RELATED TO AN OPEN WORKER'S COMPENSATION CLAIM? YES ☐ NO ☐ DATE OF INJURY: _____

SERVICES WERE PROVIDED BY: RN ☐ RNA/RPN ☐ PERSONAL SUPPORT WORKER ☐ RN/RPN FOOTCARE ☐
DURING THE WEEK COMMENCING SUNDAY _____, _____ TO SATURDAY, _____, _____ ACCORDING TO THE FOLLOWING SCHEDULE:

DATE	HOURS WORKED (INDICATE A.M. OR P.M.) A.M.	P.M.		A.M.	P.M.	HOURLY RATE	NUMBER OF HOURS	TOTAL CHARGE PER SHIFT	NAME OF INDIVIDUAL PROVIDING CARE	REGISTRATION NUMBER (IF APPLICABLE)
SUNDAY			TO							
MONDAY			TO							
TUESDAY			TO							
WEDNESDAY			TO							
THURSDAY			TO							
FRIDAY			TO							
SATURDAY			TO							
SUNDAY			TO							
MONDAY			TO							
TUESDAY			TO							
WEDNESDAY			TO							
THURSDAY			TO							
FRIDAY			TO							
SATURDAY			TO							

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.

I CERTIFY THAT THE TREATMENT OUTLINED WAS PERFORMED IN THE PATIENT'S HOME AND ALL INFORMATION PROVIDED ON THIS FORM IS ACCURATE.	**THE CHARGES LISTED ON THIS CLAIM HAVE BEEN PAID IN FULL. PLEASE REIMBURSE THE PLAN MEMBER DIRECTLY.**	**I CERTIFY THAT THE ABOVE TREATMENT WAS RENDERED. PLEASE DIRECT PAYMENT TO THE PROVIDER INDICATED ABOVE.**
_____ **SIGNATURE OF NURSING REGISTRY OFFICIAL**	_____ **SIGNATURE OF NURSING REGISTRY OFFICIAL**	_____ **SIGNATURE OF PATIENT/GUARDIAN**

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).

PLEASE MAIL TO; **GREEN SHIELD CANADA**
P.O. BOX 1606, WINDSOR, ON N9A 6W1
ATTENTION: EHS DEPARTMENT
CUSTOMER SERVICE CENTRE 1-888-711-1119 or (519) 739-1133