GREEN SHIELD CANADA

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. STUDENT INFORMATION

Student's Surname | (Student Number) **Green Shield I.D. #UMS- -00**

Street Address | City | Province | Postal Code

Home Telephone # ( ) | Work Telephone # ( ) | E-mail Address | Name of Employer: University of Manitoba Students' Union

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

First Name	Last Name	Dependant #	Date of Birth yr mm dd
			Date of Birth _____/_____/_____ yr mm dd
			Date of Birth _____/_____/_____ 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? Dep. #____ ☐ No ☐ Yes If yes, date of injury yr mm dd

   B. A motor vehicle accident? Dep. # ____ ☐ No ☐ Yes If yes, date of accident

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 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.

Student's Signature X _____ Date

F. MAILING INSTRUCTIONS

Please indicate on mailing envelope: Attention:

Professional Services	Medical Items	Out-of Country Dept. & HCSA	Vision & Accommodation
P.O. Box 1699	P.O. Box 1623	P.O. Box 1606	P.O. Box 1615
Windsor, ON	Windsor, ON	Windsor, ON	Windsor, ON
N9A 7G6	N9A 7B3	N9A 6W1	N9A 7J3

PLEASE ATTACH ALL ORIGINAL PAID RECEIPTS, PRESCRIPTIONS AND AUTHORIZATION FORMS
Please retain copies for your files as orignial receipts will not be returned

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