



AUTHORIZATION FORM FOR OXYGEN EQUIPMENT AND SUPPLIES

P. O. BOX 1623 Windsor, Ontario N9A 7B3
Attn: EHS Department
CUSTOMER SERVICE CENTRE
1-888-711-1119 or (519) 739-1133
Fax (519) 739-0046
Email: medical.authorization@greenshield.ca

To the Patient: The details requested below are mandatory in order for Green Shield Canada to determine our liability with respect to this request for oxygen equipment/supplies. For prior approval, please forward this request to the address indicated below. Failure to submit this authorization for pre-approval may result in a denial of your claim.

SECTION I - MUST BE COMPLETED IN FULL BY THE PATIENT / GUARDIAN

Patient's Name _____ Date of Birth _____ / _____ / _____
YY MM DD

Address _____ Green Shield Number _____
 _____ Telephone Number _____
 _____ Email Address _____

Do you have any other Group Insurance coverage that may include these services as benefits? Yes No
 If other coverage is Green Shield Canada, indicate Green Shield Number _____

SECTION II - MUST BE COMPLETED IN FULL BY PHYSICIAN

PLEASE ATTACH COPIES OF ARTERIAL BLOOD GASES AND/OR OXIMETRY READINGS WITH THIS REQUEST.

1) This application is: Renewal New If new, what is the set up date? _____

2) Diagnosis (please be specific): _____

3) Has an application been made to the Ministry of Health for Funding? Yes No
 If No, please provide reason. _____

(If application has been made and funding denied, please attach their denial letter.)

4) Method of Supply:
 Concentrator (including back-up and portable cylinders)
 Cylinder (compressed oxygen for stationary and/or portability)

5) Name of Oxygen Vendor (if available): _____

6) Is oxygen required: As a result of a work related injury? Yes No
 As a result of a motor vehicle accident? Yes No For sports purposes only? Yes No

PLEASE ATTACH COPIES OF ARTERIAL BLOOD GASES AND/OR OXIMETRY READING WITH THIS REQUEST.

 G.P. Specialist
 Physician's Signature _____ Date _____

 Physician's Name (Please Print) _____ Physician's Phone Number _____

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.

By signing this claim form and/or submitting actual receipts, I agree that the information provided 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 further authorize Green Shield Canada to obtain and exchange information with other parties, such as health practitioners or insurers, in order to confirm the accuracy of the submitted claim(s) information. In the event of suspected fraudulent activity pertaining to claims submitted on behalf of myself and/or my dependents, I acknowledge and agree to the disclosure of this information to relevant parties, such as the Plan Sponsor, regulatory and law enforcement agencies.

ALL CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS OF THE DATE OF SERVICE (unless otherwise stated in your benefit plan documentation). THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/PLAN MEMBER.