GreenShield Insurance

PHARMACY CLAIM SUBMISSION FORM

SECTION 1 - PHARMACY INFORMATION

PROVIDER NUMBER	PROVIDER PHONE NUMBER	CONTACT PERSON'S NAME
NAME OF PHARMACY		
ADDRESS		
CITY	PROVINCE	POSTAL CODE

SECTION 2 - MANUAL CLAIM SUBMISSION

PLAN MEMBER ID	DEP NO	SURNAME	FIRST NAME	DISPENSING DATE Y	M	D	DIN	NO SUB (1 OR 2)	QTY	RX NUMBER	DAY SUPPLY	COST	FEE	SS FEE / COB AMT	INTER-VENTION CODE	GROSS AMOUNT

SECTION 3 - COMPOUND CLAIM SUBMISSION

PLAN MEMBER ID	DEP NO	SURNAME	FIRST NAME	COMPOUND CODE	QTY	DAYS SUPPLY	RX NUMBER	DISPENSING DATE YEAR	MONTH	DAY	GROSS AMOUNT

INGREDIENTS	DIN	QUANTITY	COST
		TOTAL COST	

PROF. FEE _____

COMPOUND TIME _____

CHARGE PER MINUTE _____

TOTAL $ _____

NAME OF PHYSICIAN

_____

SECTION 4 - AUTHORIZATION

I HEREBY CERTIFY THAT THE DRUGS CLAIMED HEREON HAVE BEEN PROVIDED TO THE PERSON(S) INDENTIFIED ABOVE

_____ _____

SIGNATURE OF PHARMACIST DATE

SECTION 5 – MAILING INSTRUCTIONS

PLEASE RETAIN COPIES FOR YOUR FILES AS CORRESPONDENCE PROVIDED WILL NOT BE RETURNED

ALL CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS OF THE DATE OF SERVICE

PLEASE INDICATE ON MAILING ENVELOPE:

GREEN SHIELD CANADA INSURANCE
P.O. BOX 1652, WINDSOR, ONTARIO N9A 7G5
ATTENTION: DRUG DEPARTMENT

CUSTOMER SERVICE CENTRE 1.888.711.1119 or 519.739.1133 FAX 519.739.6483 TOLL FREE FAX 1.866.797.6483
greenshield.ca