

GreenShield™

Pharmacy Claims Manual

October 2026

TM

1. General information 1

2. Identification cards 2

2.1 Physical and digital ID cards 3

2.2 Relationship code 4

3. Pharmacy support and online resources 5

3.1 GreenShield Contact Centre 6

3.2 providerConnect resources and forms 6

3.3 Support and escalation guidance 6

4. Drug utilization review and claim responses 7

DUR modules 8
DUR messages 8
Overridable warnings 9
Information messages 9
Detailed message (response) information 9
Intervention codes 9
Claim rejections 10
Claim resubmissions 10
D9 – Call adjudicator 10
Claim reversal 10
Limitations 10
Drug/drug interactions 11
Double doctoring/multiple pharmacies 12
Compliance – fill too soon/too late 12
D7 – Fill too soon 12
DE – Fill too late 12
Overview of adjudication messages 13
Intervention codes 13
Common intervention/exception codes 14
Sample DUR claim processing and reversal intervention codes 15

5. Claim submission and general procedures 21

5.1 Claim submission options 22

5.2 Online claim processing 24

5.3 Pricing and payment 24

Ingredient cost 24
Dispensing fee 24
Co-payments and deductibles 24
Balance Billing 25
Dispensing quantities, fees, and vacation supply 25
Key units of measure 26
Billing high-cost drugs 27
Drug loyalty cards 28
Deferred payment claims 28

5.4 Dispensing and documentation rules 29
Initial days' supply for new prescriptions. . . . 29
Initial days' supply for high-cost drugs 29
Maintenance medication fill limits 29
Compliance packaging. . . . 30
Refusal to fill 31
Lost, stolen, or incorrect use of prescription medicine 31

6. Compounded medications 32
When the Compound Policy applies 33
Eligible compound cost 34
Table 1 — Ineligible compound preparations 35
Table 2 — GreenShield topical compound PINs 36
Table 3 — Additional compound PINs 37
Processing compound claims 38

7. Coordination of benefits and government programs 43

8. Drug plan coverage and eligibility 45
Product selection and interchangeable product reimbursement 46
GreenShield formularies. . . . 47
Drug special authorization 48
Maximum allowable cost 48
Limitations. . . . 49
Fertility drugs 50
Annual and lifetime drug maximums 50
Smoking cessation 50
Vaccines. . . . 50
Responsible opioid use strategy 51
Methadone 51
Buprenorphine 52
Diabetic test strips 52
Unscheduled products and natural health products 52

9. Claim audits and record-keeping 53
Member (patient) verification. . . . 54
Prescriber verification. . . . 55
Pharmacist prescribing 55
Ownership changes 55
Audit response timeline 55

Appendixes 56

Appendix A 57
Defined terms. . . . 57

Appendix B 58
Pharmacy Claim Submission Agreement 58

Appendix C 59
Frequently used PINs 59

Appendix D 59
Compliance Packaging Form. . . . 59

GreenShield is a Canadian not-for-profit organization that administers drug benefit plans and adjudicates pharmacy claims across Canada. Participating pharmacies submit claims to GreenShield on behalf of eligible plan members in accordance with the terms of the applicable benefit plan.

Drug benefit plans may cover prescription drugs and other health-related services. For pharmacy claims, participating pharmacies submit eligible prescription drug claims using the information on the member's identification card.

Most claims are submitted electronically for real-time adjudication. Depending on the plan design and service arrangement, adjudication and related administration may be provided directly by GreenShield or through GreenShield Administration on behalf of partner organizations.

If direct billing is not available, the plan member may need to pay the pharmacy and submit the claim for reimbursement. Reimbursement is subject to the applicable benefit plan, including deductibles, co-payments and other reimbursement conditions.



2. Identification cards

2.1 Physical and digital ID cards 3

2.2 Relationship code 4

2.1 Physical and digital ID cards

When a plan member presents an identification card, use the information on the card to verify the member before submitting a claim. The card may be physical or available digitally through the GreenShield+ app.



Check the following information:

Front: plan member name, identification number and company name.

The plan member identification number appears before the hyphen. The personal identification number appears after the hyphen; for the primary plan member, this is typically 00.

Spouse: typically 01; spouse after remarriage: 21, 31 or 41;

Dependents: 02, 03, 04, etc.

Back: dependent or spouse name and identification number, and the GreenShield Contact Centre toll-free number.

The identification number must correspond with the correct plan member or dependent and match the name on the prescription. For plans administered through an adjudication partner, the card may display the partner's branding and may state "**Claims adjudicated by GreenShield**."



2.2 Relationship code

Select the relationship code that matches the plan member's relationship to the cardholder when setting up the patient in the pharmacy system. The relationship code is required for adjudication under certain plans and should match the relationship recorded under the plan.

CODE	RELATIONSHIP
0	Cardholder
1	Spouse
2	Child underage
3	Child overage
4	Disabled dependent
5	Dependent student

If the relationship code appears incorrect or does not match the member's current plan information, confirm the information against the plan member's ID card. If the information on the card is correct, contact the GreenShield Contact Centre.

If the member's identity cannot be verified or improper use of an ID card is suspected, contact the GreenShield Contact Centre.



3. Pharmacy support and online resources

3.1 GreenShield Contact Centre 6

3.2 providerConnect resources and forms 6

3.3 Support and escalation guidance 6

Consult GreenShield's pharmacy support resources for assistance with claim processing, forms and other pharmacy-related matters.



3.1 GreenShield Contact Centre

Phone: 1-888-525-7587
Hours: Monday to Friday,
8:30 a.m. to 8:30 p.m. Eastern Time

Before contacting the GreenShield Contact Centre, have the necessary plan member, claim and pharmacy information available, including the pharmacy provider number.

3.2 providerConnect resources and forms

Access claim-related resources and GreenShield provider information through **providerConnect**. Prior authorization forms and other forms referenced in this manual are available through the **prior authorization forms portal**. Before completing or submitting a form, confirm that the form is current.

3.3 Support and escalation guidance

Follow the instructions in the applicable section. If the issue remains unresolved, contact the GreenShield Contact Centre or use **providerConnect** as directed.



4. Drug utilization review and claim responses

DUR modules 8
DUR messages 8
Overridable warnings 9
Information messages 9
Detailed message (response) information 9
Intervention codes 9
Claim rejections 10
Claim resubmissions 10
D9 – Call adjudicator 10
Claim reversal 10
Limitations 10
Drug/drug interactions 11
Double doctoring/multiple pharmacies 12
Compliance – fill too soon/too late 12
D7 – Fill too soon 12
DE – Fill too late 12
Overview of adjudication messages 13
Intervention codes 13
Common intervention/exception codes 14
Sample DUR claim processing and reversal intervention codes 15

Drug Utilization Review (DUR) is part of the online claims adjudication. When a claim is submitted, the system reviews the current claim together with available claims history to identify potential drug therapy concerns.

If a concern is identified, the pharmacy system returns a response message and/or response code. Review the message, assess the claim and take any action required before dispensing. DUR messaging supports, but does not replace, the pharmacist's professional judgment.

If a response cannot be resolved using the information provided through the pharmacy system, contact the GreenShield Contact Centre.

DUR modules

The online adjudication system includes prospective Drug Utilization Review (DUR) modules that identify certain drug therapy concerns at the time of claim submission, consistent with the CPhA Pharmacy Claim Standard.

The following prospective DUR modules are currently in use:

- Drug interaction alerts
- Double doctoring alerts
- Poly-pharmacy use
- Compliance-related alerts, including fill too soon and fill too late

Response codes or messages associated with the DUR process include:

CODE	MESSAGE
ME	Drug/drug interaction potential
MH	May be double doctoring
MI	Poly-pharmacy use indicated
D7	Fill too soon
DE	Fill/refill too late – noncompliant
D9	Call adjudicator

If a DUR response is returned, the pharmacist should review the message and assess the claim using professional judgment. Any action taken in response to a DUR message should be documented on the prescription record and retained for record-keeping requirements.

DUR messages

DUR message codes may be returned as either informational messages or overridable warnings. Informational messages are provided to support the pharmacist's review of the claim and do not require an intervention code. Intervention codes are optional for informational messages. Overridable warnings indicate that the pharmacist may submit an appropriate intervention code, where permitted, to continue adjudication after assessing the claim.



Overridable warnings

When an overridable warning is returned, the claim will not be approved for payment until the identified issue has been reviewed. The pharmacist must assess the warning and, where appropriate, submit the applicable intervention code together with the pharmacist ID number in order for the claim to continue through adjudication. Each overridable warning must be addressed using one or more approved intervention codes, as applicable. Once the required warning has been addressed, the claim may be paid, provided no other adjudication issues remain.

Information messages

When an informational message is returned, the claim has been approved for payment, but the system has identified a cautionary message for the pharmacist's review. These messages do not need to be answered, and an intervention code is not required to allow the claim to be paid. Informational messages indicate that a potential issue may exist and should be assessed using professional judgment by the dispensing pharmacist.

Detailed message (response) information

DUR messages may be returned on one of up to three message lines. These message lines describe the potential issue associated with the adjudication response code. Where more than three DUR messages apply, the system will return response code **DD – Insufficient space** for all DUR warnings. Additional information regarding DUR messages may be obtained by contacting the GreenShield Contact Centre.

Intervention codes

Intervention codes are used to identify the action taken by the pharmacist in response to a DUR message. An intervention code is required when responding to an overridable warning.

The table of approved CPhA messages and intervention codes is provided at the end of this section. Pharmacists should ensure that the appropriate intervention code is selected for the action taken. If an incorrect intervention code is submitted, the transaction will reject and must be resubmitted with the correct code.

If an appropriate intervention code is not available for the action taken, the pharmacy should contact the GreenShield Contact Centre for assistance.

Claim rejections

For unpaid claims that return an overridable DUR warning, the system will verify whether an acceptable intervention code and pharmacist ID number have been submitted. If the required intervention code or pharmacist ID number is missing, incomplete, or not acceptable, the claim will reject and will not be paid. The claim must be corrected and resubmitted with the appropriate information.

Claim resubmissions

The adjudication system processes each submission as a new claim and does not identify whether it is a resubmission of a previously rejected claim.

If a claim rejects because the required intervention code and/or pharmacist ID number is missing or not acceptable, the claim must be corrected and resubmitted with the appropriate information.

D9 – Call adjudicator

If the same claim for the same member and the same DIN is submitted five times on the same day and continues to deny or pend, further online submissions for that claim will not be accepted until the GreenShield Contact Centre is contacted. The GreenShield Contact Centre may provide guidance on next steps, including the appropriate intervention code to use. If the claim continues to be rejected for another reason, the message **D9 – Call Adjudicator** may continue to be returned.

Claim reversal

Claims that return an informational message are adjudicated and paid. If the prescription is subsequently changed or not dispensed within 14 days, the claim must be reversed.

Claims must also be reversed whenever a previously adjudicated claim should no longer remain payable or when the original claim details must be corrected. Pharmacies should reverse claims promptly once an error or change is identified. Where applicable, the original claim should be reversed before a corrected claim is submitted. Examples include, but are not limited to, claims for prescriptions that were not dispensed, claims submitted in error, duplicate claims, claims submitted for the wrong member, or claims where the drug, quantity, days' supply, or price must be corrected.

Limitations

The information generated through the DUR modules is provided for informational and advisory purposes only. It is intended to supplement, and not replace, the professional judgment of the pharmacist or any other health care professional involved in the provision of care.

DUR messages are not determinative of clinical appropriateness and must not be relied upon as the sole basis for dispensing decisions or patient management. Pharmacists remain responsible for exercising independent professional judgment and for considering all relevant clinical information available at the time of service.

Drug/drug interactions

This DUR module is designed to identify potential drug interactions between the prescription being submitted and other prescriptions that are considered active in the member's claims history. The module may identify potential interactions involving both single-ingredient products and combination products.

When a claim is submitted, the DIN/PIN of the current prescription is compared with the DINs/PINs of other active prescriptions in the member's claims history. If a potential interaction is identified, the system will return a response message and/or response code to alert the pharmacy.

Drug interaction messaging is based on clinical significance as determined by First DataBank and adapted for Canadian content and is intended to support the pharmacist's professional assessment of the claim. The database uses the following reference sources: Hansten's Drug Interactions, Facts & Comparisons, and the United States Pharmacopeia Dispensing Information (USPDI).

The significance levels are as follows:

Level 1	Contraindicated Drug Combination	This combination is considered contraindicated and should not be dispensed to the same member.
Level 2	Severe Interaction	Action is required to reduce risk of a serious adverse interaction.
Level 3	Moderate Interaction	Assess risk to the member and take action, as required.

If a potential interaction is identified, the claim may return the response message **Drug/Drug Interaction Potential** and/or **response code ME**.

The response message may include the following information:

- The severity code of the potential interaction
- The DIN of the historical drug
- The brand name of the historical drug, subject to message line length limitation

Overridable warnings are not payable unless an appropriate intervention code is submitted.

If more than three DUR text messages apply to a claim, the system will return the message "**Insufficient space to report all messages**" and **response code DD**. Additional message details may be obtained by contacting the GreenShield Contact Centre.

Double doctoring/multiple pharmacies

These DUR modules are intended to identify potential double doctoring or multiple pharmacy use involving drugs that may be associated with abuse or misuse.

When a claim is submitted, the system compares the therapeutic category of the current prescription with the member's claims history to identify claims within the same category that have been prescribed by different prescribers or dispensed by different pharmacies.

If a potential concern is identified, the system will return an informational response message and/or response code for the pharmacist's review.

Compliance – fill too soon/too late

When a claim is submitted, the DIN/PIN of the current prescription is compared with the DINs/PINs of previous claims for the same member. This review is based on the expected duration of therapy, using the days' supply submitted on the current claim and the member's available claims history.

D7 – Fill too soon

The Fill too soon module is designed to identify claims that are submitted earlier than expected, based on the previous dispensing date and days' supply. This may indicate possible overuse of the medication.

A Fill too soon response will return an overridable warning. In these situations, the pharmacist must assess the claim using professional judgment and, where appropriate, submit an acceptable intervention code.

The following intervention codes may be used when encountering a Fill too soon response:

CODE	MESSAGE
MK	Good faith emergency coverage established
MN	Replacement claim due to dose change
MV	Vacation supply

DE – Fill too late

The Fill too late module is designed to identify claims that are submitted later than expected, based on the previous dispensing date and days' supply. This may indicate possible underuse of the medication.

A Fill too late response is informational only.

Pharmacies must document the use of any intervention code on the prescription record and retain supporting documentation in accordance with record-keeping requirements. Claims involving overrides may be subject to audit.



Overview of adjudication messages

All claims submitted through the online adjudication system are reviewed to determine eligibility. Following adjudication, a claim may be approved, rejected, or returned with a message requiring pharmacist review or intervention.

A response code is a standard code established by the Canadian Pharmacists Association (CPhA) to identify a claim issue or adjudication outcome. Depending on the pharmacy software vendor, the response code may or may not be displayed on the pharmacy system.

The response message displayed on the pharmacy system provides a brief description of the adjudication result or issue identified. The wording of the message may vary depending on the software vendor and current claims messaging standards.

An intervention code is a standard code established by the CPhA to identify the action taken by the pharmacist in response to a claim issue or DUR warning. Depending on the pharmacy software vendor, intervention codes may appear as codes, message descriptions, or selectable options within the system

Intervention codes

Intervention codes are standard codes established by the Canadian Pharmacists Association (CPhA) to identify the action taken by the pharmacist in response to a DUR message or to indicate the application of a special coverage or payment rule.

- The use of intervention codes is described in the relevant sections of this manual.
- When an intervention code is submitted, the pharmacist ID number is mandatory.
- A maximum of two intervention codes may be submitted on a single transaction

> The use of any intervention code should be supported with relevant documentation on the prescription hard copy.

Common intervention/exception codes

CODE	MESSAGE
DA	Secondary claim – original to provincial plan
DB	Secondary claim – original to other carriers
DC	Out-of-Pocket expense paid by insured
DH	Rx synchronized pursuant to rule 19
DV	Applied to provincial plan and approved
DW	Applied to provincial plan and rejected
DX	Applied to provincial plan, decision pending
DY	Not eligible for provincial plan coverage
EQ	Valid reason to exceed days' supply limit
ER	Override days' supply limit for period
ET	Override questionable concurrent therapy
MG	Override – various reasons
MH	Override prescriber ID (if practitioner prescribing privileges have been suspended or restricted – the override should not be applied)
MK	Good faith emergency coverage established
MM	Replacement claim, drug cost only
MN	Replacement claim due to dosage change
MO	Valid claim value of $500.00 to $999.99
MP	Valid claim of $1,000.00 to $9,999.99
MQ	Valid claim-quantity over limit
MS	Non-formulary benefit
MV	Vacation supply
MY	Long term care Rx split for compliance

CODE	MESSAGE
NF	Override – quantity appropriate
NH	Initial Rx program declined
RC	Prescription cancelled by physician
SV	Approved by provincial plan. Bypass other programs
SW	Rejected by provincial plan. Bypass other programs
SX	Pending provincial plan. Bypass other programs
UA	Consulted prescriber and filled Rx as written
UB	Consulted prescriber and changed dose
UC	Consulted prescriber and changed instructions for use
UE	Consulted prescriber and changed quantity
UF	Patient gave adequate explanation. Rx filled as written
UG	Cautioned patient. Rx filled as written
UI	Consulted other sources. Rx filled as written
UD	Consulted prescriber and changed drug
UH	Counseled patient. Rx not filled
UK	Consulted other sources. Rx not filled
UL	Rx not filled. Pharmacist decision

Sample DUR claim processing and reversal intervention codes

RESPONSE CODE	MESSAGE DESCRIPTION	RESPONSE TYPE	CONDITION GENERATING RESPONSE CODE	INTERVENTION CODE BY PHARMACIST AND DESCRIPTION
ME	Drug/drug interaction potential	Severity level 2 Information message	Indicates a potential drug/drug interaction between the prescription being filled and one which the patient is already receiving. The claim has been approved for payment.	**UD** = Consulted prescriber and changed drug **UL** = Pharmacist decision Rx not filled
ME	Drug/drug interaction potential	Severity level 1 & 3 Overridable warning	Indicates a potential drug/drug interaction between the prescription being filled and one which the patient is already receiving. The claim has not been approved for payment. The claim may be processed by using the appropriate intervention codes.	**UA** = Consulted prescriber and filled Rx as written **UC** = Consulted prescriber and changed instructions for use **UB** = Consulted prescriber and changed dose **UF** = Patient gave adequate explanation. Rx filled as written **UI** = Consulted other source. Rx filled as written **UG** = Cautioned patient. Rx filled as written
MH	May be double doctoring	Information message	Indicates that the patient may be visiting multiple prescribers to obtain drugs that have a potential to be abused. The claim has been approved for payment.	**UD** = Consulted prescriber and changed drug **UL** = Pharmacist decision Rx not filled **UE** = Consulted prescriber and changed quantity
MI	Poly-pharmacy use indicated	Information message	Indicates that the patient may be visiting multiple pharmacies to obtain drugs which have a potential to be abused. The claim has been approved for payment.	**UD** = Consulted prescriber and changed drug **UL** = Pharmacist decision. Rx not filled **UE** = consulted prescriber and changed quantity
D7	Fill too soon	Overridable warning	Indicates a refill should not be required at this time. The claim has not been approved for payment. The claim may be processed by using the appropriate intervention codes.	**MK** = Good faith emergency coverage established **MN** = Replacement claim due to dose change **MV** = Vacation supply

RESPONSE CODE	MESSAGE DESCRIPTION	RESPONSE TYPE	CONDITION GENERATING RESPONSE CODE	INTERVENTION CODE BY PHARMACIST AND DESCRIPTION
DE	Fill too late	Information message	Indicates a refill is overdue at this time. The claim has been approved for payment. The dispensing pharmacist may want to ensure that the patient is compliant and taking adequate doses.	Not applicable
D9	Call adjudicator	Call Contact Centre 1-888-525-7587	Indicates that there have been excessive online submissions for the same participant on the same day for the same DIN.	As determined with the assistance of a customer service agent.
OF	Initial days' supply	Overridable warning	Indicates the first claim for this medication for a given patient. May be overridden if the patient is already established on drug.	**NH** = Initial Rx program declined
OC	Initial days' supply	Overridable warning	Indicates that a claim initially denied due to the Initial Days' Supply program was resubmitted with a reduced days' supply, but without a corresponding reduction in quantity. If it is not possible to further reduce quantity due to package size constraints, an override may be used.	**NF** = Override — Quantity appropriate
HD	Patient may qualify for government plan	Overridable warning (Ontario)	Indicates that the plan member is a senior and that the claim may qualify as a Limited Use drug through ODB. The claim has not been approved for payment. The claim may be processed using the appropriate intervention code if the plan member does not meet the criteria described by ODB for coverage of the drug product.	**MS** = Non-formulary benefit. This intervention code may be used if the plan member does not qualify for coverage by ODB for the drug claimed. **DA** = Secondary claim – original to provincial plan
KX	Patient now eligible for maintenance supply	Information message	This message may be seen when a drug claimed was previously reduced due to GreenShield's Initial Days' Supply program. The response code indicates that the quantity claimed is less than the balance remaining from the original claim. The claim has not been approved for payment. The claim may be resubmitted for the balance of the initially prescribed supply.	**MN** = Replacement claim due to dose change. For example, this intervention code may be used to allow payment when the dose has been reduced pending the results of the initial 30-day trial.

RESPONSE CODE	MESSAGE DESCRIPTION	RESPONSE TYPE	CONDITION GENERATING RESPONSE CODE	INTERVENTION CODE BY PHARMACIST AND DESCRIPTION
KR	Patient not eligible for product	Overridable warning	This may be seen on claims for narcotic preparations in children under a safe age for use. In this situation, may be overridden if the pharmacist has consulted the prescriber but the prescriber still requests the prescription filled as written.	**UA** = Consulted prescriber and filled Rx as written
DR	Days' supply lower than minimum allowable	Overridable warning	Indicates that the plan member requires a larger supply to comply with our 90-day maintenance rule. Pharmacist must use professional judgement in assessing patient eligibility to determine a clinical need for overriding.	**ER** = Override days' supply limit for period **DH** = Rx synchronized pursuant to rule 19
D6	Maximum cost exceeded	Overridable warning	Indicates that a claim cost exceeds $499.99. If cost is accurate, pharmacy must input appropriate corresponding code depending on the claim cost.	**MO** = Valid claim – value $500.00 to $999.99 **MP** = Valid claim – value $1,000.00 to $9,999.99
EQ	Reject, prov. plan enrolment required	Overridable warning	Indicates that the claim may be eligible for reimbursement under a provincial plan. If the plan member does not meet the criteria set for a restricted benefit, for example, being ineligible under the SK formulary due to age or gender restrictions, then the pharmacy can use the override code.	**DY** = Not eligible for prov. plan coverage
QQ	Drug ineligible – specialty program drug	Overridable warning (Ontario)	Indicates that the claim may be eligible for reimbursement under the Exceptional Access Program (EAP) in Ontario.	**DW** = Applied to provincial plan and rejected **DX** = Applied to provincial plan, decision pending **DY** = Not eligible for provincial plan coverage **SW** = Rejected by provincial plan. Bypass other programs. **SX** = Pending provincial plan. Bypass other programs

RESPONSE CODE	MESSAGE DESCRIPTION	RESPONSE TYPE	CONDITION GENERATING RESPONSE CODE	INTERVENTION CODE BY PHARMACIST AND DESCRIPTION
OS	Submit future claims to provincial plan	Overridable warning (British Columbia, Saskatchewan, Manitoba)	Indicates that the claim may be eligible for reimbursement under BCSA in BC, and EDS in Saskatchewan and Manitoba. An intervention code may be used if a valid override is applicable.	**DV** = Applied to provincial plan and approved **DW** = Applied to provincial plan and rejected **DY** = Not eligible for provincial plan coverage **SV** = Approved by provincial plan, bypass other programs **SW** = Rejected by provincial plan. Bypass other programs.
EE	Questionable concurrent therapy	Overridable warning	Indicates that patient is likely receiving concurrent therapy from the same drug class, i.e. GLP-1 agonists. The claim has not been approved for payment. The claim may be processed by using the appropriate intervention codes	**MK** = Good faith emergency coverage established **MN** = Replacement claim due to dose change **MV** = Vacation supply **ET** = Override questionable concurrent therapy
C6	Patient has other coverage	Overridable warning	Indicates that the member has coverage under another insurer and the claim should be coordinated with the primary payer. The claim may require submission to the other carrier before adjudication. An intervention code may be used if a valid override is applicable.	**DA** = Secondary claim – original to provincial plan **DB** = Secondary claim – original to other carriers
DX	Drug must be authorized	Information only	Indicates that the submitted drug requires special authorization approval by GreenShield before it can be processed.	For a copy of the prior authorization form, please visit **providerConnect**
MY	Duplicate drug other pharmacy	Information only	Indicates that the patient has recently received the same drug from another pharmacy and the days' supply has not sufficiently elapsed. The claim has been approved for payment. The dispensing pharmacist should review for potential duplication.	Not applicable

RESPONSE CODE	MESSAGE DESCRIPTION	RESPONSE TYPE	CONDITION GENERATING RESPONSE CODE	INTERVENTION CODE BY PHARMACIST AND DESCRIPTION
MZ	Duplicate therapy other pharmacy	Information only	Indicates that the patient has recently received a drug from the same therapeutic class at another pharmacy and the days' supply has not sufficiently elapsed. The claim has been approved for payment. The dispensing pharmacist should review for potential therapeutic duplication.	Not applicable
MX	Duplicate therapy	Information only	Indicates that the patient has recently received a drug from the same therapeutic class from the same pharmacy and the days' supply has not sufficiently elapsed. The claim has been approved for payment. The dispensing pharmacist should review for potential therapeutic duplication.	Not applicable
MW	Duplicate drug	Information only	Indicates that the patient has recently received the same drug from the same pharmacy and the days' supply has not sufficiently elapsed. The claim has been approved for payment. The dispensing pharmacist should review for potential duplicate dispensing.	Not applicable
A3	Identical claim has been processed	Overridable warning	Indicates that an identical claim for the same patient, drug, and service date has already been submitted and processed. The claim has not been approved to prevent duplicate billing and may be overridden if appropriate.	**MG** = Override – various reasons **MN** = Replacement claim due to dose change
E9	Reduced to reference based price	Information only	Indicates that the submitted drug cost exceeds the allowable reference-based price and has been reduced accordingly. The claim has been approved at the lower reimbursable amount.	Not applicable
D1	DIN/PIN/ GP #/SSC not a benefit	Information only	Indicates that the submitted product is not covered as a benefit under the patient's drug plan.	Not applicable

RESPONSE CODE	MESSAGE DESCRIPTION	RESPONSE TYPE	CONDITION GENERATING RESPONSE CODE	INTERVENTION CODE BY PHARMACIST AND DESCRIPTION
KM	Exceeds days' supply limit for this drug	Overridable warning	Indicates that the submitted days' supply exceeds the allowable limit for this drug under the patient's plan. The claim has been processed with a warning. If appropriate, the claim may be resubmitted using applicable intervention codes.	**DV** = Applied to prov. plan and approved **EQ** = Valid reason to exceed days' supply limit **MV** = Vacation supply
87	Exceeds max. # of prof. fees for this drug	Information only	Indicates that the number of dispensing (professional) fees for this drug exceeds the allowable limit. The claim has been approved for payment of the drug cost; however, the dispensing fee portion is not eligible and will not be paid.	Not applicable





5. Claim submission and general procedures

5.1 Claim submission options 22

5.2 Online claim processing 24

5.3 Pricing and payment 24

Ingredient cost 24

Dispensing fee....24

Co-payments and deductibles 24

Balance Billing....25

Dispensing quantities, fees, and vacation supply 25

Key units of measure 26

Billing high-cost drugs 27

Drug loyalty cards 28

Deferred payment claims....28

5.4 Dispensing and documentation rules 29

Initial days' supply for new prescriptions 29

Initial days' supply for high-cost drugs....29

Maintenance medication fill limits 29

Compliance packaging 30

Refusal to fill.... 31

Lost, stolen, or incorrect use of prescription medicine 31

5.1 Claim submission options

Submit pharmacy claims through Online Transaction Processing (OLTP) using the pharmacy's dispensing software whenever possible. OLTP adjudicates claims in real time and allows immediate verification of member and drug eligibility. Most claims are processed in this manner using the Canadian Pharmacists Association (CPhA) Pharmacy Claim Standard.

Transactions supported by the CPhA Pharmacy Claim Standard include, but are not limited to:

- Claim submissions
- Claim reversals
- Requests for totals and detailed records
- Daily totals and reconciliation-related responses
- Information-update transactions

If a claim cannot be submitted through OLTP, use the GreenShield Pharmacy Claim Submission Form available on **providerConnect**. Follow the submission instructions provided with the current form.

If the claim cannot be submitted electronically through the pharmacy vendor, the plan member may need to pay out of pocket and submit a manual claim using the official prescription receipt through the **GreenShield+ member portal**.

Special claims, medical equipment and supplies

Examples: compression stockings and AeroChambers.

Coverage for these items is generally not provided through the drug benefit plan, but they may qualify for coverage under the member's Extended Health Services (EHS) Plan. Claims for medical items frequently dispensed at a pharmacy can be submitted through providerConnect for real-time adjudication through Secure Services at **providerconnect.ca**.

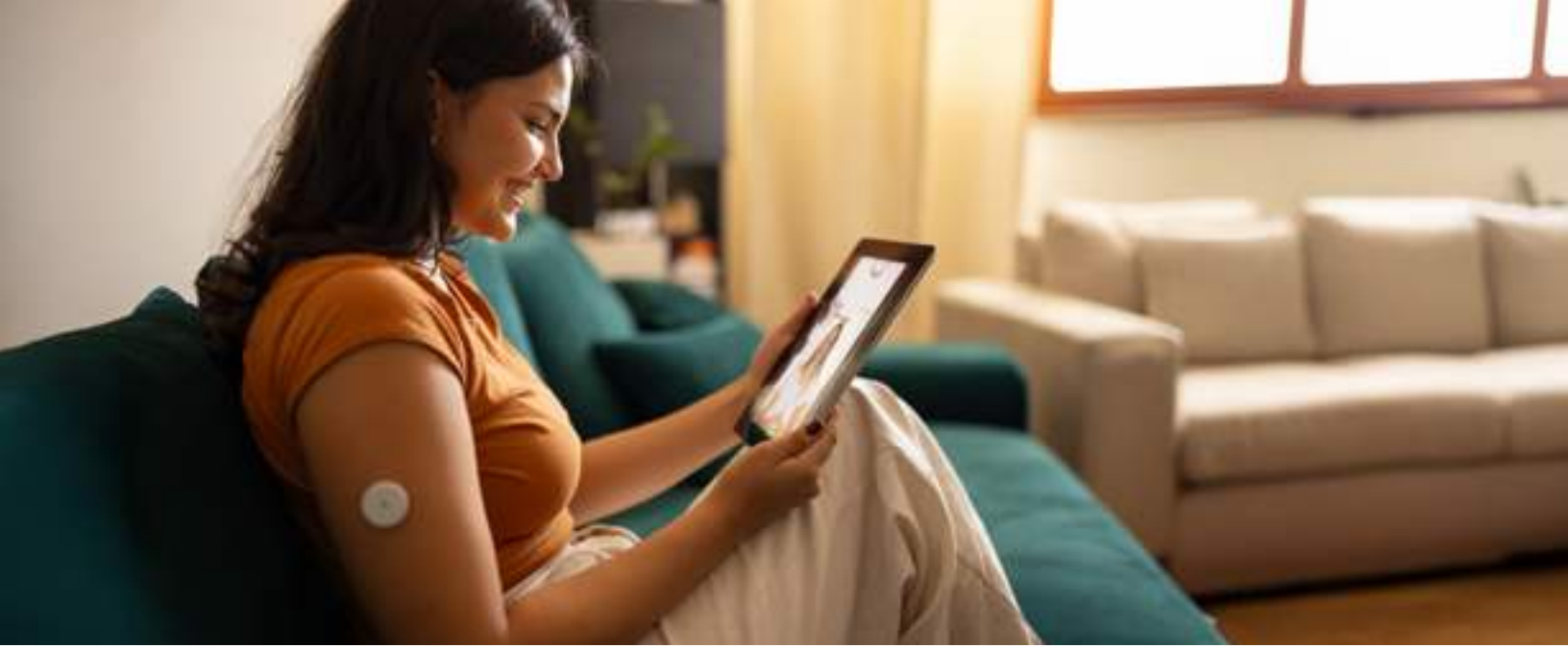
Note:

A. Items required for sports activities only or as a result of work-related injury or motor vehicle accident are not eligible. When calling for pre-authorization, advise that the patient is a resident of a hospital or long-term care facility if applicable, as this may affect eligibility for certain items.

B. Medical equipment and supplies are not subject to the patient's drug co-payment; however, they may be subject to co-payments and deductibles applicable to their EHS coverage.



Or mail claims to:
GreenShield, 8677 Anchor Drive, P.O. Box 1606
Windsor, ON, N8N 5G1
Attention: E.H.S. Department



Plan member reimbursement only

For drug benefit plans designated as Plan Member Reimbursement Only, the plan member is responsible for paying the full cost of the prescription at the pharmacy and submitting the claim directly to GreenShield for reimbursement.

Pharmacies must not submit claims to GreenShield on behalf of plan members enrolled in these plans.

Standard computer-generated official prescription receipts are acceptable for claim submission by the member. For extemporaneous compounds, the receipt must include a breakdown of all ingredients.

To support plan member reimbursement, pharmacies must provide a detailed prescription receipt including the following information:

- Pharmacy name and address
- Prescription number
- Drug name and DIN
- Medication strength
- Quantity dispensed
- Days' supply
- Dollar amount paid
- For compounds, a breakdown of all ingredients

> Receipts must include all required prescription details. Cash register receipts or payment transaction records alone are not acceptable for claim processing.

5.2 Online claim processing

When a pharmacy submits a claim through OLTP, the claim is adjudicated in real time and the result is returned through the pharmacy's dispensing software. A claim may be approved, rejected or returned with a message requiring review or further action.

If a claim is rejected, review the response message and correct the information where possible before resubmitting. If an adjudicated claim should no longer remain payable, or if claim details need correction, submit a reversal. Where applicable, reverse the original claim before submitting the corrected claim.

Maximum time to submit claims

Claims, resubmissions, and reversals, whether submitted online or manually, must be received for processing within 12 months of the original date of service. The 12-month period is measured from the date the drug was originally dispensed and is not extended by correction, resubmission, or reversal activity. After 12 months from the original date of service, transactions are not eligible for processing. The standard 12-month period may vary depending on the plan design.

5.3 Pricing and payment

Ingredient cost

For claims adjudication purposes, GreenShield recognizes ingredient cost as the eligible cost of the drug ingredient(s), determined by the provincial formulary price, or by the manufacturer's list price (MLP) or wholesale cost price, in each case including the relevant markup. Costs other than ingredient cost are deemed included in the dispensing fees. **Not applicable in Quebec.**

Dispensing fee

GreenShield will reimburse one professional fee for each prescription dispensed. In Ontario, reimbursement is limited to the lesser of the pharmacy's usual and customary posted fee or the GreenShield weighted average professional fee as determined by GreenShield. In provinces other than Ontario, the applicable provincial base professional fee will be used. **This section does not apply in Quebec.**

Co-payments and deductibles

Drug benefit plans may include a variety of co-payment and deductible arrangements. Member responsibility is determined at the time of adjudication and will be communicated through the online claims system.

A co-payment may be a fixed dollar amount per prescription (for example, $0.35, $1.00, or $2.00), a percentage of the total prescription cost (for example, 10%, 20%, or 30%), or an amount related to the pharmacy dispensing fee.

A deductible may apply on an individual or family basis and may be assessed either annually, over a 12-consecutive-month period beginning with the first prescription claim, or from the effective date of the member's coverage, depending on the plan design.

Pharmacies must collect any co-payment or deductible amount indicated through adjudication. Amounts communicated by the online system must be applied as adjudicated.

Balance Billing

Balance billing is not permitted except in the limited circumstances outlined below. If the total of GreenShield's allowed amount and the member's applicable co-payment is less than the pharmacy's usual and customary charge, the pharmacy may charge the member the difference only in the following situations:

Dispensing fee difference: In Ontario and Quebec only, where the pharmacy's usual and customary dispensing fee exceeds the maximum dispensing fee reimbursed under the plan.

Brand-name drug requested: Where the member chooses a brand name product instead of an interchangeable generic equivalent, and the plan does not allow reimbursement of the brand price under a no-substitution rule, the member may be charged the difference in cost.

Excess quantity dispensed: Where the quantity dispensed exceeds the plan's maximum allowable supply, the member may be charged for the portion in excess of the covered amount.

Any amount charged to the member outside of these permitted exceptions is considered non-compliant. Pharmacies are expected to maintain appropriate documentation to support any charges that exceed the adjudicated benefit and applicable co-payment amount, as claims may be subject to audit. Unsupported or non-compliant billing may result in claim adjustment, recovery of funds, or other remedies available under the Pharmacy Claim Submission Agreement. In addition, non-compliance may result in monetary penalties, including a warning for the first offence, a $500 penalty for the second offence, a $1,000 penalty for the third offence, and a $2,000 penalty for the fourth offence. Repeated non-compliance may result in the suspension or termination of the Pharmacy Claim Submission Agreement for a fifth offence. GreenShield also reserves the right to immediately suspend or terminate the Pharmacy Claim Submission Agreement where the non-compliance constitutes a material breach of the Pharmacy Claim Submission Agreement or the Pharmacy Claim Manual.

Dispensing quantities, fees, and vacation supply

Prescription claims will be processed in the amount prescribed, up to a maximum of 100 days' supply. The allowed dispensing fee will be paid in accordance with the provincial fee schedules.

As an exception, vacation supplies may be covered for members travelling outside their country of residence, up to a maximum of 183 days' supply. For vacation supply claims exceeding 100 days' supply, GreenShield will reimburse fees as follows:

TOTAL DAYS' SUPPLY SUBMITTED	DISPENSING FEE REIMBURSED
Up to 100 days	1 dispensing fee
101-120 days	1.33 times the dispensing fee
121-150 days	1.66 times the dispensing fee
151-183 days	2 dispensing fees

To qualify for reimbursement of more than one dispensing fee, the days' supply must be entered on the claim submission. If the days' supply field is left blank, reimbursement will be limited to one dispensing fee. To identify the claim as a vacation supply and as an exception to the standard 100-day supply limit, the **intervention code "MV"** must also be submitted on the claim.

If the full vacation supply cannot be adjudicated online, the member may be required to pay the pharmacy directly for the amount exceeding the allowable online submission and submit a manual claim with supporting receipts for reimbursement of any eligible amount, subject to the terms of the benefit plan.

Pharmacies must maintain clear and complete documentation for all vacation supply requests. Documentation must include a signed request from the plan member for a vacation supply, as well as the duration and specific dates of travel. Pharmacies must also maintain documentation demonstrating that the quantity dispensed is appropriate for and corresponds to the travel period. All records must be maintained on file, associated with the claim, and readily retrievable for audit purposes. Failure to maintain adequate supporting documentation may result in claim reversal and recovery of paid amounts.

Key units of measure

The unit of measure should correspond to the product's dosage form. Commonly used units are listed below:

DOSAGE FORM	UNIT OF MEASURE	EXAMPLES
Tablets, capsules, or caplets	Number of tablets, capsules, or caplets	30 tablets, 60 capsules, 90 caplets
Creams or ointments	Weight in grams	15 g tube, 30 g tube, 60 g jar
Patches	Number of patches	30 patches
Suppositories	Number of suppositories	24 suppositories
Liquid, oral	Volume in millilitres	150 mL bottle
Liquid, injectable	Volume in millilitres or number of vials	10 mL vial, 2 vials
Pre-loaded syringes, pens, or autoinjectors	Number of syringes, pens, or autoinjectors	4 prefilled syringes, 2 pens, 1 autoinjector
Nebulizer solutions and inhaled medications	Number of doses	120 doses
Powder for injection	Grams or number of vials	2 g vial, 1 vial
Sprays	Number of doses	120 doses



Billing high-cost drugs

Certain high-cost drug claims submitted through the online adjudication system may require special billing procedures due to system dollar limits.

For online claims with a value of more than $1,000.00 and less than $9,999.99, the claim must be submitted using **intervention code MP**.

For online claims with a value greater than $9,999.99, the claim may need to be submitted in multiple transactions. The first submission should be made using intervention code MP. If additional submissions are required for the remaining balance, the appropriate **duplicate override code MP + MG** must be used on the subsequent submissions. The dispensing fee may be billed only once and must be included on the first submission only. It must not be included on any subsequent submissions.

Where a high-cost drug claim also requires coordination of benefits, the claim may need to be split into multiple submissions due to the limit on the number of intervention codes that can be submitted on a single transaction. For the first submission, the claim should be submitted using the appropriate **coordination of benefits intervention code (DA or DB) together with MP**. If additional submissions are required for the remaining balance, the subsequent claim(s) should be submitted using the appropriate **coordination of benefits intervention code (DA or DB) together with MG**, where applicable.

If a high-cost drug claim cannot be successfully submitted online due to system limitations, the pharmacy may need to submit the claim through the manual claim submission process on **providerConnect**.

Claims for high-cost drugs may be subject to audit. Pharmacies must retain documentation supporting the amount billed, the sequence of submissions, and any intervention codes used.

Drug loyalty cards

Drug or brand loyalty cards are manufacturer-sponsored payment cards that may assist members with the cost of an eligible higher-cost brand-name drug. These programs are separate from public and private drug benefit plans.

Where a drug loyalty card is used, the claim must first be submitted to the drug benefit plan or plans in the correct payer order. If an unpaid eligible amount remains after adjudication, that amount may then be submitted to the loyalty card program, subject to the terms and conditions of that program.

If the member is covered under only one drug benefit plan (private or public), the claim should be submitted to that plan first, followed by the loyalty card program for any remaining eligible amount. Where GreenShield is the member's drug benefit plan, the claim must be submitted to GreenShield before it is submitted to the loyalty card program.

If the member is covered under two drug benefit plans (private or public), the claim should be submitted to the primary plan first, then to the loyalty card program, and then to the other drug benefit plan, if an unpaid eligible amount remains.

Claims involving drug loyalty cards may be subject to audit. Pharmacies are expected to retain documentation supporting the order of submission and any amounts paid by other plans or programs, where applicable.

Deferred payment claims

Under the GreenShield Deferred Payment Plan, claims are submitted by the pharmacy for adjudication, with payment collected directly from the plan member. Reimbursement is subsequently issued to the plan member by GreenShield. The steps in this plan design are:

- The pharmacy submits the claim online to GreenShield for adjudication.
- The pharmacy receives response codes QJ and RC:
  - **QJ – Deferred payment**; patient to pay pharmacist
  - **RC – Transmitted to insurer**
- The plan member pays the pharmacy in full at the time of dispensing.
- Reimbursement to the plan member is processed by GreenShield on the fifth calendar day following claim submission. A four-day hold is applied to allow for claim reversal if required.

For plan members with secondary coverage, reimbursement from GreenShield must be completed and a claim statement issued prior to submission to the secondary payer.

5.4 Dispensing and documentation rules

Initial days' supply for new prescriptions

To help reduce medication waste, the initial fill of a new prescription is generally limited to a maximum 30-day supply.

A prescription is considered new if the member has not had a paid claim for the same drug within the previous 12 months, regardless of the pharmacy used. Changes in strength, dosage, manufacturer, or brand, including generic substitution, are not considered new prescriptions for this purpose.

If the submitted days' supply exceeds 30 days, the claim will reject with response code **OF – Initial Rx days' supply exceeded**. The claim may be resubmitted with a reduced days' supply. If the days' supply is reduced without a corresponding quantity reduction, the claim will reject with response code **OC – Quantity reduction required**. Where the prescribed quantity cannot reasonably be reduced, override code **NF – Override-quantity appropriate** may be used.

Where application of the initial 30-day supply limit is not appropriate, the pharmacist may use professional judgment and submit override code **NH – Initial Rx program declined**. The reason for the override must be documented on the prescription record and retained for audit purposes. Unsupported use of override codes may result in claim adjustment or recovery in accordance with the Provider Agreement.

This limitation applies broadly to drug benefit plans, subject to plan design and product-specific exceptions. It does not apply to insulin. Certain products may also be excluded where the smallest available package size exceeds a 30-day supply. Prescriptions for less than a 30-day supply are not affected.

Initial days' supply for high-cost drugs

Certain high-cost drugs may be limited to an initial supply of up to 10 days. Once the member has demonstrated tolerance to therapy, subsequent fills may be limited to a maximum 30-day supply, subject to plan provisions.

This approach is intended to reduce medication waste and support the safe use, handling, and storage of high-cost or potentially hazardous medications.

Maintenance medication fill limits

Certain maintenance medications may be subject to fill frequency and minimum days' supply requirements. For drugs listed on **providerConnect**, coverage is generally limited to a maximum of five fills per year, and claims must be submitted for at least a three-month supply.

If a claim for an eligible maintenance medication is submitted for less than the minimum required days' supply, the claim will reject with response code **DR – Days' supply lower than minimum allowable**. In situations where dispensing a three-month supply is not appropriate, an intervention code may be used, provided the reason is clearly documented on the prescription record.

The following intervention codes may be used, where appropriate:

CODE	MESSAGE
ER	Override days' supply limit for period
MN	Replacement claim due to dose change
MY	Long term care Rx split for compliance
DH	Rx synchronized pursuant to rule 19

Members with a history of five or more maintenance medications may be automatically identified by the system and exempted from this requirement. Members who are not automatically exempted and believe they qualify may submit a request for review using the exemption form. A copy of this form is included in **Appendix D** and is available on **providerConnect**. Requests will be reviewed and, where appropriate, an exemption may be granted.

Claims submitted using an intervention code or exception request may be subject to audit. Pharmacies are expected to retain documentation supporting the reason for more frequent dispensing, including any relevant clinical rationale. Unsupported use of intervention codes or exception requests may result in claim adjustment or recovery in accordance with the Provider Agreement.

Compliance packaging

Compliance packaging may be covered when provided to support medication adherence and when the patient meets the coverage criteria. Coverage automatically applies when five or more maintenance medications are dispensed in shorter days' supply quantities, such as 7, 14, or 28 days. Exceptions may be considered where there is documented clinical need, such as cognitive or physical limitations. Only medications that are appropriate for multi-dose packaging should be included, as some medications may not be suitable for this type of dispensing.

Where coverage is requested for the additional dispensing fee associated with compliance packaging, or where an exception to maintenance medication fill limits is needed, the exception request form must be completed and submitted. A copy of this form is included in **Appendix D** and is available on **providerConnect**.

Compliance packaging claims may be subject to audit. Pharmacies are expected to confirm that coverage requirements have been met before dispensing and to retain appropriate documentation to support exception requests. Reimbursement may be adjusted if claims do not meet the requirements.

Refusal to fill

GreenShield may reimburse pharmacies for a refusal to fill when the pharmacist determines, in the exercise of professional judgment, that a prescription should not be dispensed. Pharmacists have always had the right and responsibility to refuse to fill certain prescriptions based on their professional judgment.

Examples of situations where a refusal to fill may be appropriate include:

- Therapeutic duplication
- Suboptimal response to therapy
- Adverse drug reaction
- Dangerously high dose
- Suspected false or altered prescriptions

To support reimbursement, the pharmacy must retain documentation that clearly supports the refusal to fill. At a minimum, the documentation must include:

- Any discussion between the prescriber and the pharmacist, where applicable
- Any outcome of that discussion
- Communication with the member regarding the outcome

Situations that are not eligible for reimbursement as a refusal to fill include, but are not limited to:

- Medication not available in inventory or is backordered
- Claim returns a DUR response (for example, refill too soon)
- Prescription is changed to an eligible benefit

> Refusal to fill claims may be subject to audit. Pharmacies must retain supporting documentation in a readily retrievable format. If a claim cannot be substantiated, payment may be reversed in accordance with the Provider Agreement.

Lost, stolen, or incorrect use of prescription medicine

GreenShield provides coverage for the initial dispensing of eligible prescription medication. Claims for replacement of medication due to loss, theft, damage, or misuse are not eligible for reimbursement and will not be adjudicated for payment, unless permitted under specific plan provisions.



Billing a refusal to fill claim

To submit a refusal to fill claim:

- Enter the DIN of the prescribed drug in the pharmacy dispensary software system.
- Enter the value "**1**" in the Special Service Code field, the Quantity field, and the Days' Supply field.
- Enter $22.00 in the Special Service Fee field.
- Adjudicate the claim online.

Additional requirements

- Reimbursement is available only for claims adjudicated by GreenShield where GreenShield is the first payer.
- Coordination of benefits does not apply for refusal to fill claims.
- Refusal to fill claims are payable only through online adjudication or a Deferred Drug Plan where the pharmacy provider receives claim payment.
- Manual claims are not eligible for payment.



6. Compounded medications

When the Compound Policy applies 33
Eligible compound cost. 34
Table 1 – Ineligible compound preparations. 35
Table 2 – GreenShield topical compound PINs . . .36
Table 3 – Additional compound PINs 37
Processing compound claims 38

GreenShield's Compound Policy applies to compounded medication claims under participating benefit plans. Plan-specific variations may apply.

Before submitting a compound claim, confirm that the compound meets GreenShield's eligibility requirements, the appropriate DIN or PIN and compound code are used, only eligible ingredient costs and fees are included, and the required documentation is complete.

When the Compound Policy applies

A claim for a compound medication is eligible for coverage if it meets all of the following conditions:

1. It does not duplicate the formulation, specifically the strength and route of administration, of a commercially manufactured product marketed in Canada, nor can the desired dose be obtained using commercially manufactured products; AND
2. The main therapeutic ingredient aligns with any frequency restrictions or requirements on the plan; AND
3. The compound is not listed as ineligible in **Table 1** (page 35); AND
4. The ingredients comply with the following compound submission rules:

   For **non-topical compounds**, enter one DIN of an eligible ingredient based on the plan member's benefit plan.

   For **topical compounds**, claims should be submitted using the DIN or NPN associated with the primary active ingredient. The DIN or NPN of the primary active ingredient must be eligible under the plan member's benefit plan.

   The primary ingredient is defined as the main drug substance responsible for the intended therapeutic effect of the preparation. In mixtures with varying proportions (e.g., 40%–20%–20%), the DIN corresponding to the ingredient in the highest concentration must be submitted. Where multiple ingredients are present in equal proportions, the DIN of the highest-cost ingredient must be used.

   If the primary ingredient does not have a DIN, pharmacists must submit a PIN associated with the appropriate medication category that includes eligible component(s). Refer to **Table 2** (page 36) for GreenShield compound PINs. Additional benefits outlined in **Table 3** (page 37) may apply to non-standard plans.

> For Quebec plan members only, any extemporaneous compounded product is eligible for coverage provided it is an eligible RAMQ benefit.



Eligible compound cost

The total eligible compound drug cost is the sum of the drug cost and the dispensing fees.

- The eligible drug cost is the combined cost of all ingredients used in the compound, including therapeutically inactive components such as diluents, solvents, fillers, preservatives, sweeteners, and stabilizers. Costs for units beyond those used in the compound (e.g. the remainder of vials or bottles) will not be considered for reimbursement and must not be submitted as compound ingredients.
- The dispensing fees include both the standard dispensing fee and the compound dispensing fee. The compound dispensing fee is capped based on the specific compound code and the maximum allowable preparation time. **The reimbursed amount is set at $1.10 per minute.**
- Details related to the compound cost, markups, and fees should be included in separate fields. GreenShield requires a breakdown of all ingredients used in the compound through computer-generated pharmacy software to process the claim.

Some plans include a maximum dispensing fee. For plans with a dispensing fee cap, the compounding fee is covered only up to the allowed maximum. Any excess amount may be payable by the member. In accordance with the National Pricing Policy, pharmacies cannot bill members for the difference between GreenShield's allowed fee and their own dispensing fee, except in Ontario, where this is allowed.

> The above fee structure does not apply in Quebec.

Table 1 – Ineligible compound preparations

The Compound Drug Policy protects drug plans and plan members from compound drugs that have not been proven efficacious and safe. Compound drugs that are potentially ineffective, unsafe, or that may lead to abuse or misuse, are not eligible for coverage.

Compounds containing ingredients from the table below are standardly not eligible for coverage, even if prescribed or combined with an eligible ingredient. This list is not exhaustive, and additional exclusions may apply. GreenShield reserves the right to update this list at any time and at its sole discretion.

INGREDIENTS

- Ammoniated mercury
- Arsenic
- Baclofen (topical)
- Biobase-G
- BPC-157
- Carbamazepine (topical)
- Clonidine (topical)
- DMAE (dimethylaminoethinol)
- DMPS (dimercaptopropanesulphonate)
- DMSA (dimercaptosuccinic acid)
- DNCB (dinitrochlorobenzene)
- Gabapentin (topical)
- Glycolic acid
- HRT (hormone replacement therapy)
- Hydroquinone
- Ketamine (topical)
- Kojic acid
- Liothyroxine (T3)
- Mandelic acid
- Mercurochrome
- Minoxidil
- NSAID (non-steroidal anti-inflammatory drug)
- Titanium dioxide
- Vitamin K (topical)
- Yohimbe

FORMATS

- Compounds for gummies, lollipops, lozenges, or troches
- Compounds for slow, sustained, or timed-release products

REASON FOR USE

- Cosmetic use (e.g. hair re-growth compounds, skin rejuvenation, muscle gain)

OTHER

- Illegal drugs
- Unauthorized injectable peptide products (please consult examples here)

Table 2 — GreenShield topical compound PINs

All topical compounds must be submitted with the adequate corresponding listed compound PIN. GreenShield reserves the right to update this list at any time and at its sole discretion.

PIN	DRUG CATEGORY	PRIMARY ACTIVE INGREDIENT (defined as the main drug substance responsible for the intended therapeutic effect of the preparation)	
993018	Antibiotic compound	• Amikacin • Cefazolin • Clindamycin • Erythromycin • Gentamicin	• Metronidazole • Neomycin • Tobramycin • Vancomycin
993026	Corticosteroid compound	• Betamethasone • Clobetasol • Demeclocycline • Desonide	• Dexamethasone • Hydrocortisone • Methylprednisolone • Triamcinolone
993034	Antifungal compound	• Ciclopirox • Clotrimazole • Fluconazole • Itraconazole	• Ketoconazole • Miconazole • Nystatin
993042	Skin treatment compound	• Benzoin tincture • Camphor • Coal tar • Doxepin • Lactic acid (>17%) • Liquid carbonis detergens • Menthol • Methenamine • Salicylic acid (40% or greater)	• Sodium Thiosulfate • Sucralfate • Sulfacetamide • Sulfur • Tar distillate • Thiabendazole • Urea • Verapamil
993050	Pain treatment compound (without narcotics)	• Amantadine • Amitriptyline • Benzocaine • Bupivacaine	• Cyclobenzaprine • Lidocaine • Phenazopyridine
993069	Narcotic pain treatment compound	• Codeine • Methadone	• Morphine • Oxycodone
993077	Miscellaneous eligible compound	• Cantharidin • Diltiazem • Fluorouracil	• Glycopyrrolate • Nifedipine

Table 3 — Additional compound PINs

These ingredients are not standard benefits but may be covered under select plans. A rejected PIN indicates that the product is not eligible under the plan.

PIN	DRUG CATEGORY	PRIMARY MEDICINAL INGREDIENT (defined as the main drug substance responsible for the intended therapeutic effect of the preparation)
900001	Compounded hormone replacement therapy (HRT)	• Progesterone • Estrogen (e.g. Tri-est, Estradiol, Bi-est) • Dehydroepiandrosterone (DHEA)
900087	Compounded topical anti-inflammatories (NSAIDS)	• Aspirin • Celecoxib • Diclofenac • Flurbiprofen • Ibuprofen • Indomethacin • Ketoprofen • Ketorolac • Meloxicam • Naproxen • Piroxicam
966436	Triple P (Triple therapy, Trimix, Trimix regular multidose)	• Prostaglandin powder (alprostadil powder) Please note that the use of alprostadil in any other dosage form other than the powder is not eligible (e.g. Prostin VR, alprostadil injection).
900699	Client Choice Eligible Compound	If the Compound Policy is waived (i.e. the policy does not apply to the plan), all topical and non-topical compounds are considered eligible.
993972	Gender-Affirming Hormone Therapy (GAHT)	• Estradiol valerate

Duplicating a commercially available product

Compounds duplicating commercially available products are not eligible for coverage, except in cases of documented backorder. During a backorder, if no therapeutic alternatives exist within the same drug class, compounds may be submitted using **PIN 993980 – Eligible Compound – Drug Shortage.** Claims will be reimbursed only until the product becomes available. The pharmacy must retain documentation confirming the backorder during that timeframe, as claims may be subject to audit.

Processing compound claims

Step 1: DIN availability

If a DIN is available, submit the DIN for the primary ingredient for topical compounds, or any eligible DIN for non-topical compounds. If no DIN is available, enter the corresponding PIN listed in **Table 2** or **Table 3**. Refer to **When the Compound Policy applies** for detailed submission requirements.

Step 2: Enter the corresponding compound code

CODE		CODE	
EXTERNAL		INTERNAL	
0	Topical cream	**3**	Internal use liquid
1	Topical ointment	**5**	Internal powder
2	External lotion	**6**	Injection or infusion
4	External powder	**7**	Ear/eye drop
		8	Suppository
		9	Compounded other

Step 3: Enter the time required to prepare the compound

The maximum billable time for the corresponding compound code is indicated below.

CODE	TYPE OF COMPOUND	MAXIMUM ALLOWED TIME for billing purposes
0	Compounded topical cream	20 minutes
1	Compounded topical ointment	20 minutes
2	Compounded external lotion	20 minutes
3	Compounded internal use liquid	20 minutes
4	Compounded external powder	20 minutes
5	Compounded internal powder	30 minutes
6	Compounded injection or infusion	20 minutes
7	Compounded eye/ear drop	30 minutes
8	Compounded suppository	30 minutes
9	Compounded other	20 minutes



Pharmacists should only bill the actual time it takes to prepare the compound and can follow a general guideline of not more than 5 minutes per ingredient.

GreenShield reimburses at $1.10 per minute when calculating the eligible compounding fee. GreenShield may apply a maximum allowable compound fee that varies by province and is based on the compound code and number of components.

> This fee structure is not applicable in Quebec.

Step 4: Record all other pertinent and applicable information

- Date of preparation
- List of all ingredients with their respective quantity
- Cost charged for each ingredient
- Initials of compounder and/or pharmacist responsible for the preparation and verification of hard copy
- Written formula used
- If a compound is prepared by another pharmacy, the name of the preparing pharmacy and the preparation details
- Any other documentation required by the provincial regulatory authority

Step 5: Submit the claim



7. Coordination of benefits and government programs



Coordination of benefits (COB) is available through the online claims adjudication system and may apply where a member has coverage under more than one public or private drug plan.

Where GreenShield has been advised of dual coverage, claims will be coordinated in accordance with the industry guidelines. In general, a claim should be submitted first to the plan that covers the person as a plan member, before submitting any unpaid portion to a plan that covers the person as a dependent. For dependent children covered under more than one parent's plan, the primary payer is typically the plan of the parent whose birthday occurs earliest in the calendar year.

When GreenShield is the secondary payer, reimbursement will be limited to the remaining amount, up to the full eligible price of the drug in accordance with GreenShield pricing rules. If the pharmacy's submitted charge is higher than the eligible amount recognized by GreenShield, the difference is not reimbursable and is not eligible for a manual pricing adjustment. Pharmacies must not bill the member for any non-reimbursable difference unless the charge is specifically permitted under the Provider Agreement and adjudication rules. See **Co-payments and deductibles** in Section 5 for more details.

Claims must be submitted in the correct payer order. Where a public plan is the first payer, the claim must be submitted to the public plan before it is submitted to GreenShield, and then any manufacturer-funded assistance programs last, if applicable.

GreenShield supports electronic coordination of benefits involving more than two payers. If GreenShield is the third payer, the appropriate intervention code must be entered to continue adjudication.

Coordination of benefits also applies to compound claims. COB claims may be subject to audit, and pharmacies must retain supporting documentation where required.



8. Drug plan coverage and eligibility

Product selection and interchangeable product reimbursement 43
GreenShield formularies 44
Drug special authorization 45
Maximum allowable cost 45
Limitations 46
Fertility drugs 47
Annual and lifetime drug maximums 47
Smoking cessation 47
Vaccines 47
Responsible opioid use strategy 48
Methadone 48
Buprenorphine 49
Diabetic test strips 49
Unscheduled products and natural health products 49

Coverage is determined at adjudication using the member's plan parameters. Use the claim response returned through the pharmacy system to confirm eligibility and reimbursement. Do not infer coverage outside the adjudication response unless GreenShield policy expressly permits an override.

Plan members should consult their plan documentation or the GreenShield member portal for current information about their specific coverage.

Product selection and interchangeable product reimbursement

For products designated as interchangeable under the applicable provincial formulary, reimbursement is generally based on the lowest-cost interchangeable product, subject to the member's plan provisions and provincial requirements. In most cases, if a lower-cost interchangeable product is available, GreenShield will reimburse up to the price of that product.

Product selection rules may vary by plan. Depending on the member's coverage, reimbursement may be based on one of the following approaches:

Patient or Prescriber Choice: reimbursement of the prescribed brand product may be allowed when either the prescriber or the member requests no substitution.

Prescriber Only Choice: reimbursement of the prescribed brand product may be allowed only when the prescriber requests no substitution.

Mandatory Product Selection: reimbursement is limited to the lowest-cost interchangeable product, regardless of whether no substitution is requested.

When a no substitution request is made, the appropriate indicator must be entered in the product selection field at the time of claim submission. If the submitted product is higher in cost than the amount eligible under the member's plan, the member may be responsible for the difference.

Pharmacies are expected to submit claims using the appropriate product selection indicator and to retain any supporting documentation required to substantiate reimbursement of a higher-cost product. Claims may be subject to audit, and incorrect or unsupported use of no substitution indicators may result in claim adjustment or recovery in accordance with the Provider Agreement.

The following indicators are used when submitting claims for product selection:

OLTP SYSTEM	MESSAGE
1	Doctor no substitution
2	Patient no substitution
3	Lowest cost brand in the pharmacy inventory
4	Existing therapy



GreenShield formularies

Plan sponsors may implement customized formularies that determine the eligibility of drug products under an individual's benefit plan. As a result, coverage for the same drug may vary between plan members.

Drug eligibility is adjudicated in real time based on the member's specific plan parameters within the GreenShield system. Coverage may be influenced by factors such as drug listing status under the plan, the availability of alternative or substitute products, cost-management rules established by the plan sponsor, and clinical or authorization requirements. In some cases, plan rules may also limit coverage for certain products based on when they were introduced or whether they meet specific formulary criteria. When special authorization is required, the applicable form may be obtained through **providerConnect** or the member portal, completed by the patient and prescriber, and submitted to GreenShield for assessment.

Pharmacists are to rely on the claim response returned at the time of adjudication to determine coverage. If a drug is not eligible, the response will indicate that the product is not a benefit, for example through a response code such as D1, and the full cost is the responsibility of the patient. If a drug requires special authorization, the response will indicate that authorization is required, for example through a response code such as DX, and the claim will not be payable unless approval is obtained. Reimbursement is available only while the special authorization approval remains in effect in accordance with plan rules.

Formulary coverage, reimbursement levels, and eligibility criteria are subject to change at the discretion of the plan sponsor and may be updated without notice. Pharmacists are not to interpret, infer, or assume drug coverage outside of the claim response returned by the GreenShield system. Claim responses are to be followed as adjudicated and are not to be overridden unless an override is expressly permitted and supported under GreenShield policy.

Plan members should be directed to their plan documentation or the GreenShield member portal for the most current information regarding their specific coverage.

Drug special authorization

Certain drugs may require special authorization before coverage can be considered under the member's plan. If an electronic claim rejects with the message **DX – Drug must be authorized**, the pharmacy should access the applicable Drug Special Authorization form through **providerConnect** and provide it to the member for completion by the member and prescriber. The completed form must be submitted to GreenShield for assessment. Coverage decisions will be communicated directly to the member upon completion of the assessment. Incomplete submissions may delay the review process.

Claims for drugs requiring special authorization should not be resubmitted as though coverage has been approved unless approval has been confirmed. Claims related to special authorization requests may be subject to audit. Pharmacies are expected to retain documentation supporting any submission or follow-up related to the claim.

Specialty care program

Some GreenShield plan sponsors have chosen plan designs that require plan members to obtain certain specialty drugs from pharmacies participating in the Specialty Care Program. Claims submitted for these drugs by pharmacies that are not part of the program network will be denied in accordance with plan design. For all plan members prescribed drugs that are part of the Specialty Care Program, the plan member must obtain prior approval from GreenShield. Because of this approval process, information about the program will be provided to the plan member at the time approval is granted.

> This program does not apply in Quebec.

Maximum allowable cost

The Maximum Allowable Cost (MAC) option sets a maximum dollar amount for the eligible portion of a prescription within a therapeutic class of drugs. The eligible amount reimbursed is based on the cost of the most cost-effective drug within that class. The price of the most cost-effective drug in the class is used to set the eligible amount that will be reimbursed.

This option currently applies to the following drug classes. Additional classes may be added.

- Proton Pump Inhibitors (PPIs)
- HMG-CoA Reductase Inhibitors (statins)
- Angiotensin Converting Enzyme Inhibitors (ACEI)
- Angiotensin Receptor Blockers (ARB)
- Selective Serotonin (5-HT1) Receptor Agonists (Triptans)
- Diuretics
- Calcium Channel Blockers (Non-Dihydropyridine)
- Calcium Channel Blockers (Dihydropyridine)
- Beta-Adrenergic Blocking Agents (Beta Blockers)
- Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)



A drug benefit plan may include some or all of these MAC drug classes as part of its plan design. Additional drug classes may be incorporated into this pricing arrangement over time. When a claim is reduced with MAC pricing, the response code **E9 – Reduced to reference based price** will be returned.

Limitations

Common exclusions under most plans

The following products are commonly excluded under most drug benefit plans:

- Diaphragms, condoms, contraceptive foams and jellies, or appliances normally used for contraception
- Natural Health Products (NHPs), including oral vitamin products, herbals, and homeopathic products
- Cosmetic products
- Atomizers, appliances and prosthetic devices, and diagnostic monitoring equipment
- Drugs and/or devices that are considered experimental or investigational, or for which Notice of Compliance has not been issued or has been withdrawn
- Products that do not have a Drug Identification Number (DIN)
- Biological sera, preventive immunization vaccines, or injectables that are not prescribed or administered by a qualified medical practitioner, or that are supplied under any federal, provincial, or municipal health program
- Prescriptions for which the member is eligible for coverage through the Workplace Safety & Insurance Board (WSIB)
- Prescriptions reimbursable through a federal, provincial, or municipal agency or foundation
- Prescriptions arising from a motor vehicle accident
- Medications for which the member is eligible under a provincial drug benefit plan

Fertility drugs

Some drug benefit plans include specific coverage restrictions for fertility drugs. These may include products such as follicle stimulating hormone, luteinizing hormone, nafarelin, cetrorelix, and other medications used in the treatment of infertility.

Other plans may provide coverage for fertility drugs through the pharmacy claims system but apply separate maximums or limitations specific to fertility drugs that may differ from those applied to other drug categories under the plan.

Annual and lifetime drug maximums

Some drug benefit plans apply an annual or lifetime maximum to drug coverage. Once the member has reached the applicable maximum under the plan, any further drug costs become the responsibility of the member.

Pharmacies should follow the adjudication response at the time of claim submission. If the member has reached the applicable maximum, the claim may reject or return a reduced payable amount, and the member will be responsible for any amount not covered under the plan.

Smoking cessation

Some drug benefit plans provide coverage for smoking cessation products, subject to plan-specific limits. Eligible products may include nicotine patches, gum, sprays, lozenges, and certain prescription smoking cessation medications.

Coverage, eligible products, quantity limits, duration limits, and reimbursement rules may vary by plan and will be determined at adjudication. Pharmacies should submit claims through the usual adjudication process to confirm the member's coverage and any applicable limitations.

Vaccines

GreenShield coordinates vaccine coverage with publicly funded immunization programs, where applicable. Eligibility for vaccine claims is determined based on the member's specific plan within the GreenShield system. Coverage may vary based on jurisdiction, public funding status, age, and other applicable plan or clinical requirements. Pharmacists are to rely on the claim response returned at the time of adjudication to determine whether a vaccine is eligible under the member's plan. Plan members seeking clarification regarding vaccine coverage should be directed to their plan materials or member portal.

Responsible opioid use strategy

GreenShield may apply opioid utilization management and safety monitoring measures to support the appropriate use of opioid medications, subject to plan design. These measures form part of GreenShield's Responsible Opioid Use Strategy, which includes the Responsible Access to Opioid Drugs Policy and the Safe Opioid Use for Chronic Pain Management Program. This strategy may include measures such as abuse-deterrent formulation requirements, 30-day supply limits, long-acting opioid coverage controls, and safety monitoring for chronic opioid use.

For members receiving opioids for chronic pain management, the Safe Opioid Use for Chronic Pain Management Program may monitor opioid utilization using morphine equivalent dose thresholds and may also identify the use of certain high-risk combinations, including opioids used with other medications that may increase the risk of harm. If defined thresholds are reached, GreenShield may initiate a safety review and request supporting clinical information from the prescriber, which may include the treatment plan, underlying medical conditions, and any specialist referral or alternative therapies. If the required information is not received within the applicable timeframe, coverage may be discontinued or suspended until the information is reviewed. This process does not apply to treatment for cancer-related pain, palliative care, acute pain, or opioid dependence therapy.

GreenShield may also apply dispensing and coverage controls to opioid claims under the Responsible Access to Opioid Drugs Policy. These may include limits on days' supply, including up to a 30-day supply for certain higher-risk medications, requirements for abuse-deterrent formulations where applicable, and prior authorization or other coverage requirements for selected opioid products, including certain long-acting formulations.

Methadone

Methadone must be submitted using an eligible commercially available product, based on the clinical indication set out in the product monograph. Commercially available methadone products are not eligible for submission as compounds.

For substance abuse treatment, the quantity dispensed must be adjudicated in milliliters. Pharmacies may submit either one total claim for the quantity dispensed or separate daily claims, depending on how the medication is provided. Where daily claims are submitted, up to seven claims may be submitted per patient on a single day, provided each claim represents one day of treatment. Any additional claim submitted for the same day of treatment will be rejected as a duplicate claim. A usual and customary dispensing fee is payable on the first witnessed-dose claim submitted for each day. Alternatively, one claim may be submitted for up to seven days for the total quantity dispensed. Claims for carries are adjudicated using GreenShield reimbursement rules. Each patient receiving methadone for substance abuse treatment is limited to a maximum of 365 doses per year.

Where compounded methadone stock solution remains permitted under provincial or territorial requirements, one claim per day may be submitted. Reimbursement is limited to the professional fee and compounding fee. These claims are subject to audit and may be adjusted where submitted claim information is not supported by the corresponding records.

For pain or palliative care, methadone must be submitted using an eligible commercially available product in accordance with the approved indication as outlined in the applicable product monograph.



Buprenorphine

Buprenorphine for substance abuse treatment is limited to one claim per patient, per dosage strength, per day. The claim must include the witnessed dose and any authorized carry doses for the days' supply submitted. Any additional claim for the same dosage strength submitted for the same patient on the same day is not eligible and will be rejected as a duplicate claim. A usual and customary dispensing fee is payable on the total claim.

Diabetic test strips

Coverage for diabetic test strips may be subject to annual quantity limits based on the member's insulin use status. Unless otherwise specified by the plan, the following limits apply beginning on the date of the first paid claim:

- Non-insulin dependent diabetics: up to 600 strips per year
- Insulin-dependent diabetics: up to 3,000 strips per year

Claims submitted above the applicable annual limit may be reduced or declined at adjudication. Pharmacies should follow the adjudication response at the time of claim submission.

Unscheduled products and natural health products

Drug products that are unscheduled by the National Association of Pharmacy Regulatory Authorities (NAPRA) are not eligible for coverage under most drug plans. Coverage may apply only when explicitly included under the applicable plan design.

Products classified as Natural Health Products and assigned a Natural Product Number (NPN) by Health Canada are also not eligible for coverage under most drug benefit plans. Coverage may apply only where explicitly included under the applicable plan design.



9. Claim audits and record-keeping

Member (patient) verification 51
Prescriber verification 52
Pharmacist prescribing. 52
Ownership changes. 52
Audit response timeline 52

GreenShield may review pharmacy claims for prescription drugs, compounds, and medical equipment before or after payment to confirm that claims are accurate, complete, and supported by the products or services provided. Reviews may include documentation requests, desk audits, focused claim verification, and on-site or virtual audits.

GreenShield may notify the pharmacy of an audit or documentation request in writing, by secure portal communication, by remittance message, or by other reasonable means. The audit notice may identify the claims under review, the documentation required, and the timeframe for response.

Pharmacies must maintain complete, accurate, and legible records sufficient to support all claims submitted to GreenShield and must provide such records upon request within the timeframe specified in the audit notice. Documentation may be requested in paper or electronic format, provided the records are complete, readable, and capable of being verified.

At a minimum, records must be sufficient to substantiate:

- Plan member name and address
- Prescription or product details (drug name, DIN, strength, or description of equipment or supplies)
- Quantity dispensed or supplied
- Days' supply, where applicable
- Amount charged to the plan member
- Date the prescription was written, or the equipment or supplies were received
- Date the prescription was dispensed, or the equipment or supplies were supplied
- Any intervention codes submitted

Where an on-site or virtual audit is conducted, the pharmacy is expected to cooperate fully and provide reasonable access to the records, systems, and supporting documentation required to verify the claims under review. GreenShield may request clarification from pharmacy staff where necessary to confirm claim accuracy and compliance with the Provider Agreement and Pharmacy Claims Manual.

If the requested documentation is not provided within the required timeframe, is incomplete or illegible, or does not substantiate the claim as submitted, GreenShield may reverse payment, adjust the claim, offset the amount against future remittances, or seek repayment, as applicable. GreenShield will notify the pharmacy of any resulting adjustment. Repeated non-compliance, failure to cooperate with an audit, or submission of claims that cannot be substantiated may also result in additional corrective action, including suspension or termination of claim submission privileges under the Provider Agreement.

Member (patient) verification

As part of GreenShield's audit, claim-validation and quality-assurance activities, GreenShield may contact plan members or their authorized representatives to verify prescription pick-up, receipt of medications or services, claim information, and other details relevant to the assessment, review, and validation of claims submitted for reimbursement.

Prescriber verification

During an audit, investigation, or claim-validation activity, GreenShield may contact prescribers to validate prescription authorizations, confirm prescribing information, and verify that prescriptions, prescription changes, renewals, or other prescribing activities were authorized by the identified prescriber.

Pharmacist prescribing

Where pharmacist prescribing is authorized by applicable legislation and regulatory requirements, GreenShield may accept claims prescribed by a pharmacist acting within their scope of practice. Pharmacies are expected to maintain appropriate supporting documentation, which may be requested for claim validation, audit, or investigation purposes.

Ownership changes

In the event of a pharmacy ownership change, merger, acquisition, transfer, or corporate restructuring, the pharmacy must notify GreenShield in advance and cooperate with any audit, claim review, or reconciliation activities. Any outstanding audit, investigation, documentation request, claim adjustment, reversal, or recovery process must be completed before the ownership change can be finalized. The pharmacy remains responsible for providing supporting documentation and resolving all outstanding claim matters related to the period preceding the ownership change. GreenShield reserves the right to recover claim payments, offsets, or adjustments identified through audit activities occurring before or after the ownership change.

Audit response timeline

Pharmacies must submit all audit responses and supporting documentation within fourteen (14) calendar days of GreenShield's request. Documentation received after the response deadline may not be considered.

GreenShield will not accept appeals or responses relating to claims reimbursed in excess of the maximum allowable cost, claims containing markups that exceed applicable provincial reimbursement limits, or claims submitted for quantities exceeding the prescribed quantity. Such claims may be subject to adjustment, recovery, or reversal.

Amounts identified as owing through the audit process may be remitted to GreenShield by cheque or, at GreenShield's discretion, recovered through the withholding of future payments until the outstanding audit recovery amount has been fully satisfied.



Appendixes

Appendix A
Defined terms 54
Appendix B
Pharmacy Claim Submission Agreement. 55
Appendix C
Frequently used PINs. 56
Appendix D
Compliance Packaging Form 56

Appendix A

Defined terms

The following definitions apply to key terms used throughout this manual.

TERM	DEFINITION
Adjudication	The process by which a claim is assessed to determine eligibility, reimbursement, and member responsibility at the time of submission.
Assigned Claim	A claim submitted by a pharmacy on behalf of a plan member, with the eligible benefit paid directly to the pharmacy.
Audit	A review conducted by GreenShield to verify the accuracy, validity, and compliance of claims. Reviews may include pre-payment review, post-payment review, desk audit, documentation request, focused claim verification, utilization review, and on-site or virtual audit.
Balance Billing	Charging a plan member the difference between the amount submitted by the pharmacy and the amount allowed or reimbursed by the payer, excluding permitted member cost-sharing amounts.
Claim	A request submitted by a pharmacy or plan member for reimbursement of eligible products or services under a drug benefit plan.
Claim Reversal	The cancellation of a previously adjudicated claim when it should no longer remain payable or when the original claim details must be corrected.
Coordination of Benefits (COB)	The process for determining the order of payment when a member is covered under more than one public or private drug plan, so that total reimbursement does not exceed the eligible amount.
Days' Supply	The number of days a dispensed quantity of medication is expected to last based on the prescribed dosage and directions for use.
Deferred Payment Claim	A claim submitted by the pharmacy for online adjudication where the plan member pays the pharmacy directly at the time of dispensing and is subsequently reimbursed by the drug benefit plan.
Eligible Amount	The amount recognized by the drug benefit plan for reimbursement after applying plan provisions, pricing rules, formulary status, and any other applicable limits.
Formulary	The list or set of rules under a member's plan that determines whether a drug product is eligible for reimbursement and under what conditions.
Ingredient Cost	The eligible cost of the drug ingredient or ingredients used to determine reimbursement, based on the applicable pricing source and markup rules.
Manual Claim	A claim submitted outside the online adjudication system using paper or electronic documentation for later processing.
Maximum Allowable Cost (MAC)	A pricing option that sets a maximum eligible amount for a prescription within a therapeutic class of drugs.
Member (Plan Member)	An individual covered under a drug benefit plan, either as the cardholder or as an eligible dependent.
Online Transaction Processing (OLTP)	The real-time electronic claims submission process used to adjudicate pharmacy claims at the point of service.
Pharmacy Provider	A licensed pharmacy enrolled with GreenShield and authorized to submit pharmacy claims.
Pseudo-DIN (PIN)	A product identifier used for items without a standard DIN, including certain supplies and GreenShield-designated eligible products.
Remittance	The payment and related claim-level information issued to the pharmacy after adjudication, including any messages or adjustments.
Response Message	The message returned during adjudication that provides additional explanation or context for a response code.
Special Authorization	A review process requiring approval before certain drugs are eligible for reimbursement under the member's plan.
Usual and Customary Price	The pharmacy's regular charge for a drug or service, used when determining dispensing fee reimbursement and member billing.
Vacation Supply	An exception to the standard days' supply limit that may allow a larger quantity to be dispensed for a member travelling outside their country of residence, subject to the member's plan and documentation requirements.

Appendix B

Pharmacy Claim Submission Agreement

The Pharmacy Claim Submission Agreement is generated electronically on providerConnect®.

- To access the agreement, visit **www.providerconnect.ca** and navigate to "Provider Registry."
- Select "Pharmacy" from the drop-down menu to access the enrolment form. The enrolment form is available at: **https://www.providerconnect.ca/ProviderEnrolment/PharmacyAccount.aspx**
- Complete all required fields and submit the form.
- A Provider Service Agreement will be generated based on the submitted information. The agreement can then be printed for the pharmacy's records.

In the event of a change in pharmacy ownership, the provider must complete a GreenShield Pharmacy Account form through providerConnect in the Provider Registry, under Pharmacy. The form includes fields specific to changes in ownership and must be completed and submitted in full.

Upon submission of the form, the provider must print two copies of the Provider Service Agreement by selecting the Provider Service Agreement link on the confirmation page. Both copies of the agreement must be signed and dated and then returned to GreenShield by email to **support@providerconnect.ca**.

Once the required documentation has been received and processed, one signed copy of the agreement will be returned to the pharmacy for its records.

Appendix C

Frequently used PINs

Pseudo-DINs (PINs) should be used for products that do not have a standard DIN, including items assigned a PIN by the applicable provincial formulary, as well as certain GreenShield-designated items such as diabetic supplies, lancets, and other eligible products.

Claims for these items are adjudicated on a cost + fee basis. The product cost, markup, and pharmacy professional fee must be entered in the appropriate separate fields at the time of claim submission.

- To access the list, visit **providerconnect.ca** and navigate to "**What You Need**", then select "**Pharmacy Provider.**"
- From the pharmacy menu, under Pharmacy Manuals, select "**Frequently Used PINs for Billing Purposes**" to download the latest list.

Appendix D

Compliance Packaging Form

Before completing or submitting the **Compliance Packaging Form**, confirm that the version being used is current. The form is available through **providerConnect**.

GreenShield™

1-888-525-7587
greenshield.ca

™/® Trademarks owned by Green Shield Association and used under license. © 2026 Green Shield Canada Insurance. All rights reserved.
Green Shield Canada Insurance, 8677 Anchor Drive, PO Box 1606, Windsor, ON N9A 6W1 1-888-711-1119