P.O. BOX 1623 WINDSOR, ONTARIO N9A 7B3
Attn: EHS Department (519) 739-1133 or
Customer Service Centre 1-888-711-1119

AUDIO CLAIM FORM

THIS CLAIM FORM MUST BE FILLED OUT FOR ALL PAY PLAN MEMBER CLAIMS

PROVIDER

Provider No. Telephone No.

Name

Street Address

City Province Postal Code

PATIENT

Green Shield Identification No.

Name

Street Address

City Province Postal Code

To be Completed by the Patient/Guardian

1) Are these services required due to a work related injury? **Yes** ☐ **No** ☐

2) Are these services required due to an automobile accident? **Yes** ☐ **No** ☐

3) Do you have any other audio coverage? **Yes** ☐ **No** ☐

If yes, please provide Insurance Company name_____

If other coverage is Green Shield, indicate Green Shield number_____

For Ontario Residents:
A copy of the ADP form must accompany this claim. If this is not an ADP claim, please explain why and provide a copy of this audiogram.

For All Other Provinces:
Provide copy of audiogram.

Hearing Aid recommended by: ENT ☐ **Otolaryngologist** ☐

Audiologist ☐ **Family Doctor** ☐

Name:_____
(please provide name of above)

Diagnosis (reason for aid):_____

Date of Service (pickup date) _____/_____/_____
yy mm dd

DESCRIPTION OF HEARING AID

RECEIVER TYPE (Please Check)

	Conventional	Programmable	Digital
BTE	☐ R-70410 ☐ L-70400	☐ R-70910 ☐ L-70900	☐ R-70735 ☐ L-70730
ITE	☐ R-70610 ☐ L-70600	☐ R-70810 ☐ L-70800	☐ R-70725 ☐ L-70720
ITC	☐ R-70510 ☐ L-70500	☐ R-70925 ☐ L-70920	☐ R-70710 ☐ L-70700
CIC	☐ R-70710 ☐ L-70700		

By signing this claim form and/or submitting actual receipts, I agree that the information provided on this form is complete and accurate. I understand that the information provided by me to Green Shield Canada about myself and my dependents, will be used by Green Shield Canada for claims adjudication and any other services necessary in the administration of our benefits which may include the exchange of information with other parties to administer this benefit claim. I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.

CHARGES

	LEFT AID TOTAL CHARGES	RIGHT AID TOTAL CHARGES
ACQUISITION COST		
MOLD		
OPTIONS (LIST)		
DISPENSING FEE		
SUBTOTAL		
ADP/Provincial Plan ALLOWANCE		
TOTAL		
REPAIR- MANUFACTURER (COPY OF INVOICE REQUIRED)		
REPAIR- PROVIDER		
OTHER: (i.e. Batteries, Returns)		

PATIENT/GUARDIAN

I UNDERSTAND THAT THE CHARGES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY AGREEMENT BENEFITS.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE SUPPLIER FOR THE COST OF THOSE SERVICES. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS FORM.

SIGNATURE OF PATIENT /GUARDIAN

PATIENT/GUARDIAN

ONLY COMPLETE THIS SECTION ON THE DATE OF PICKUP, AND ONLY IF THIS FORM IS COMPLETED.

I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE ABOVE NAMED PROVIDER AND AUTHORIZE PAYMENT DIRECTLY TO HIM.

SIGNATURE OF PATIENT /GUARDIAN

THERE IS NO NEED TO ATTACH A RECEIPT IF THIS FORM HAS BEEN COMPLETED AND IF THIS AREA HAS BEEN SIGNED.

THE CHARGES LISTED ON THIS CLAIM HAVE BEEN PAID IN FULL BY THE PLAN MEMBER. PLEASE PAY PLAN MEMBER FOR ELIGIBLE CHARGES.

SIGNATURE OF PROVIDER

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