CLAIM FORM FOR HEARING AIDS

Please use one form per location, per participant. There is no need to attach receipts if this form is completed in full by the provider(s).

SECTION 1 – PATIENT INFORMATION

GREEN SHIELD ID NUMBER	COMPANY NAME	PROVIDER NUMBER	PROVIDER PHONE #

SURNAME	FIRST NAME	DATE OF BIRTH (YY/MM/DD)	PROVIDER NAME

ADDRESS	ADDRESS

CITY	PROVINCE	POSTAL CODE	CITY	PROVINCE	POSTAL CODE

SECTION 2 – MANDATORY DECLARATION

Do you have any other group insurance coverage that may include these services as benefits? **YES** ☐ NO ☐

If Yes, please provide Insurance company's name_____ **AND attach copy of statement from primary carrier.**

If other coverage is Green Shield, indicate Green Shield ID number:_____

Is treatment due to a motor vehicle accident? YES ☐ NO ☐ Date of accident (YY/MM/DD)_____

Is treatment related to an open Worker's Compensation claim? YES ☐ NO ☐ Date of injury (YY/MM/DD)_____

SECTION 3a – PRESCRIBER / DISPENSER INFORMATION

THIS SECTION IS MANDATORY FOR CLAIMS CONSIDERATION – FAILURE TO COMPLETE IN FULL MAY RESULT IN DENIAL OF CLAIM*

PRESCRIBER: ☐ **AUDIOLOGIST** ☐ **MEDICAL DOCTOR** **NAME AND LICENSE NUMBER OF PRESCRIBER** _____

DISPENSER INFORMATION: ☐ **AUDIOLOGIST** ☐ **HEARING INSTRUMENT PRACTITIONER(HIP)** ☐ **OTHER**_____

NAME OF DISPENSER_____

I certify that I have personally assessed the patient named on this form. Based on my assessment I confirm his/her medical needs for these devices. I confirm that the patient has hearing loss sufficient to warrant use of a hearing device on a long-term basis as part of his/her total daily activities.

I CONFIRM THAT ALL INFORMATION CONTAINED ON THIS FORM IS TRUE AND ACCURATE.

SIGNATURE OF DISPENSING AUDIOLOGIST / HEARING INSTRUMENT PRACTITIONER ☐ **LICENCE #** ☐ **DATE :** ☐

SECTION 3b – CLAIM DETAILS AN AUDIOGRAM MUST BE SUBMITTED WITH ALL CLAIMS

DATE OF DISPENSING:_____
YEAR MONTH DAY

ITEMS DISPENSED: ☐ HEARING AID(S) ☐ NOISE CANCELLING DEVICES ☐ FM SYSTEM ☐ BICROSS ☐ _____

FREE PRODUCTS / SERVICES PROVIDED: _____

DIAGNOSIS: (REASON FOR AID)

_____

MAKE & MODEL:_____ SERIAL #_____

RECEIVER TYPE: CONVENTIONAL ☐ LEFT ☐ RIGHT
DIGITAL ☐ LEFT ☐ RIGHT

☐ OTHER_____

REPAIR ONLY: CHARGE: LEFT AID $_____
RIGHT AID $_____

MANUFACTURER ☐ RIGHT ☐ LEFT (COPY OF INVOICE REQUIRED)
PROVIDER ☐ RIGHT ☐ LEFT

CHARGES:	LEFT AID	RIGHT AID
All amounts indicated must represent the total amounts charged (less any discount/warranties provided)		
TOTAL COST OF AID		
PROVINCIAL ALLOWANCE (if applicable)		
BATTERIES		
OTHER FEES – indicate below (e.g., accessories)		
1.		
2.		
3.		

SECTION 4 – AUTHORIZATION

I UNDERSTAND THAT THE CHARGES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY BENEFIT PLAN. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE SUPPLIER FOR THE COST OF THOSE SERVICES	COMPLETE THIS SECTION ON THE DATE OF PICK UP. I CERTIFY THAT THE ABOVE TREATMENT WAS RENDERED AND HEREBY ASSIGN PAYMENT DIRECTLY TO THE PROVIDER.	THE CHARGES LISTED ON THIS CLAIM HAVE BEEN PAID IN FULL BY THE PATIENT. PLEASE REIMBURSE PATIENT DIRECTLY..
SIGNATURE OF PATIENT OR LEGAL GUARDIAN	**SIGNATURE OF PATIENT OR LEGAL GUARDIAN**	**SIGNATURE OF PROVIDER**

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

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

SECTION 5 – MAILING INSTRUCTIONS

PLEASE ATTACH ALL ORIGINAL CORRESPONDENCE and retain copies for your files as original receipts will not be returned. ALL CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS OF THE DATE OF SERVICE (unless otherwise stated in your benefit plan documentation). THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/PLAN MEMBER.

CUSTOMER SERVICE CENTRE 1-888-711-1119 or (519) 739-1133

PLEASE INDICATE ON MAILING ENVELOPE: GREEN SHIELD CANADA P.O. BOX 1623, WINDSOR, ON N9A 7B3 ATTENTION: CLAIMS DEPARTMENT greenshield.ca