P.O. BOX 1615 Windsor, Ontario N9A 7J3
Attn: Childcare Program
Customer Service Centre 1-888-711-1119 or (519) 739-1133

# CHILDCARE CLAIM FORM

**Please complete separate claim form for each month and for each child being claimed. There is no need to attach receipts if this form is completed in full, including authorized signatures of the Employee/Parent or Guardian and a facility official.**

## CHILDCARE PROVIDER INFORMATION

| | | | |
|---|---|---|---|
| **Childcare Provider No.** | | **Not for Profit** ☐ **For Profit** ☐ | |
| **Childcare Facility Name** | | **Telephone Number** ( ) | |
| **Address** | **City** | **Province** | **Postal Code** |

## PLAN MEMBER INFORMATION

| | |
|---|---|
| **Employee Name** | **Employer** |
| **Child's Name** Last First | **Child's Green Shield ID No.** |
| **Address** | **Child's Date of Birth** _____/ _____/ _____ Y M D |

**Do you have any other Childcare Coverage? Yes** ☐ **No** ☐ **(If yes, attach copy of payment statement or denial letter from primary carrier.)**

**If Yes: -Other Green Shield Plan?** ☐ **Green Shield I.D. No.**_____

**-Government Subsidy?** ☐ **Other?** ☐ **Explain:**_____

## CLAIM INFORMATION (Must be completed in full by Facility.)

**Claim Submission for: Start Date**_____ **End Date**_____

| Facility Rates | # of HALF DAYS Being Claimed | # of FULL DAYS Being Claimed | # of Before/After School Program DAYS Being Claimed | Total Amount Charged by Facility (Rate x # of Days/Week) |
|---|---|---|---|---|
| **Half Day** $ | | | | $ |
| **Full Day** $ | | | | $ |
| **Weekly** $ | | | | $ |
| **Monthly** $ | | | | $ |
| **Before/After School Program** $ | | | | $ |

**Total amount of Government or other subsidy for this period: $**_____

## TO BE COMPLETED IN ALL CASES

**I CERTIFY THAT THE CHILDCARE SERVICES AS LISTED ABOVE ARE ACCURATE. 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 MY SUPPLIER FOR THE COST OF THOSE SERVICES. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS FORM**

_____ _____

**DATE (Y/M/D)** **EMPLOYEE / PARENT OR GUARDIAN**

**I CERTIFY THAT THE ABOVE CLAIM INFORMATION IS ACCURATE. THE CHILDCARE CHARGES FOR EACH DAY BILLED WERE REQUESTED BY THE CHILD'S PARENT OR GUARDIAN.**

_____ _____

**DATE (Y/M/D)** **AUTHORIZED FACILITY SIGNATURE**

| REQUIRED ONLY IF CHILDCARE FACILITY IS BILLING GREEN SHIELD DIRECTLY | REQUIRED ONLY IF CHARGES HAVE BEEN PAID IN FULL BY PLAN MEMBER |
|---|---|
| **I HEREBY ASSIGN TO THE ABOVE CHILDCARE FACILITY ALL OF THE CHILDCARE BENEFITS PROVIDED BY MY SAID COVERAGE OR SO MUCH THEREOF AS MAY SERVE TO SATISFY MY INDEBTEDNESS OR THAT OF MY DEPENDENT CHILD TO THE SAID FACILITY FOR THIS PERIOD OF COVERAGE.** | **THE CHARGES LISTED ON THIS CLAIM HAVE BEEN PAID IN FULL. PLEASE REIMBURSE PLAN MEMBER DIRECTLY.** |
| _____ **EMPLOYEE / PARENT OR GUARDIAN** | _____ **AUTHORIZED FACILITY SIGNATURE** |

**I am authorized by my spouse and/or dependents to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.**

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

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

| | |
|---|---|
| **All claims must be submitted within 12 months of the date of service (unless otherwise specified in your benefit plan documentation).** | **The cost, if any, of obtaining this information is at the expense of the Patient/Guardian/Plan Member.** |