CLAIM REVERSAL REQUEST

Green Shield Canada
P.O. Box 1606, Windsor, ON N9A 6W1
1-888-711-1119 or (519)739-1133

Benefit Type:

☐ Drug	☐ Dental	☐ Audio
☐ Medical Items	☐ Professional Services	☐ Child Care
☐ Vision Care	☐ Hospital Accommodation	☐ _____

Provider Name:	Green Shield Provider #:	
Patient Name:	Green Shield ID	Dep. No.
Date of Service:	Form I.D. **#** (Internal Use Only):	
Procedure Code / DIN:	Rx #:	
Description of Product/Service:		
Claim Paid Amount:	Payee Type: ☐ Provider ☐ Plan Member	

Have you received a cheque?

☐ No

☐ Yes If yes, what is the status of the cheque? ☐ Cashed ☐ Destroyed

Reversal Reason:

_____

_____

_____

_____

_____

☐ Please reprocess original claim with requested change.

Requested By:

_____ _____
Name of Authorized Individual (Please print) Telephone Number

_____ _____
Signature Date

By signing this claim form, 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 will be used by Green Shield Canada for claims adjudication.

Please fax to: Green Shield Canada
(519) 739-0046