



CLAIM REVERSAL REQUEST

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

Benefit Type:

- | | | |
|--|---|-------------------------------------|
| <input type="checkbox"/> Drug | <input type="checkbox"/> Dental | <input type="checkbox"/> Audio |
| <input type="checkbox"/> Medical Items | <input type="checkbox"/> Professional Services | <input type="checkbox"/> Child Care |
| <input type="checkbox"/> Vision Care | <input type="checkbox"/> Hospital Accommodation | <input type="checkbox"/> _____ |

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: <input type="checkbox"/> Provider <input type="checkbox"/> Plan Member	
Have you received a cheque? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, what is the status of the cheque? <input type="checkbox"/> Cashed <input type="checkbox"/> Destroyed			
Reversal Reason: <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <input type="checkbox"/> 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			