



# HEALTH CARE SPENDING ACCOUNT CLAIM SUBMISSION FORM

*This form should be used when claiming reimbursement under your Health Care Spending Account, Health Care Expense Account or Health Services Spending Account for eligible expenses which are not covered (or not covered in full) by your Health or Dental Plan.*

Green Shield I.D. #	Alternate I.D. #	Date of Birth
Surname	First Name	____ / ____ / ____ YY MM DD
Mailing Address		Telephone No. (    )
City	Province	Postal Code

Do you have any other Group Insurance coverage that may include these services as benefits? Yes  No

If yes, please provide Insurance Company name \_\_\_\_\_

If other coverage is Green Shield, indicate Green Shield number \_\_\_\_\_

Be sure you have first submitted these claims to any provincial health insurance, or any private health care plan you may have (including another Green Shield plan, spousal plan, etc.)

I want my eligible expenses paid from my Green Shield health plan or dental plan **first** and any unpaid portions of my eligible expenses paid from my HCSA

I want all my eligible expenses paid from my Green Shield health plan or dental plan **first**, then any unpaid portions of my eligible expenses paid from my other Green Shield # \_\_\_\_\_ and if still unpaid portion remaining, paid under my HCSA.

I want all my eligible expenses paid directly from my HCSA.

**NOTE:** *If no box has been checked, we will pay claims according to Box 1.*

### HEALTH CARE EXPENSES (Please include receipts, prescriptions, etc.)

Description of Expense	Date of Expense	Name	Dependent #	Amount

<b>Total Amount Claimed</b>	<b>\$</b>
-----------------------------	-----------

<p>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.</p> <p>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.</p> <p>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.</p>	<p>Subject to the limitations of Revenue Canada and the rules and regulations of the plan, I hereby authorize Green Shield to charge the above claim to my Health Care Spending Account.</p> <p>_____ Signature of Plan Member</p> <p>_____ Date</p>
---	--

**Mail this form and enclosures to: GREEN SHIELD CANADA  
Attention: Health Care Spending Account**

**PLEASE INDICATE ON MAILING ENVELOPE**

Drug Dept. P.O. Box 1652, Windsor, ON N9A 7G5	Professional Services, P.O. Box 1699, Windsor, ON N9A 7G6
Medical Items, P.O. Box 1623, Windsor, ON N9A 7B3	Other Claims, P.O. Box 1606, Windsor, ON N9A 6W1
Vision/Hospital Dept. P.O. Box 1615, Windsor, ON N9A 7J3	Dental Dept. P.O. Box 1608, Windsor, ON N9A 7G1

**To avoid additional postage costs, please submit multiple claims in one envelope to any of the addresses listed above. When in doubt, choose the "OTHER CLAIMS" address.**

**For inquiries contact: CUSTOMER SERVICE CENTRE Toll Free 1-888-711-1119 or 519-739-1133**

The cost, if any, of obtaining this information is at the expense of the Patient/Plan Member.