



PHARMACY ADJUSTMENT FORM

SECTION 1 – PHARMACY INFORMATION

PROVIDER NUMBER	PROVIDER PHONE NUMBER	CONTACT PERSON'S NAME
NAME OF PHARMACY		
ADDRESS		
CITY	PROVINCE	POSTAL CODE

REASON CODES FOR ADJUSTMENT

1 – PRODUCT SELECTION CODE MISSING – PLEASE INDICATE: 1 OR 2
 2 – WRONG QUANTITY
 3 – MULTIPLE SIZE (i.e.: 1ML, 5ML, 10ML – INDICATE PACKAGE SIZE DISPENSED)
 4 – NO OF MONTHS SUPPLY
 5 – CHANGE IN GROSS AMOUNT (COST + FEE)
 6 – WRONG DIN USED
 7 – RX CANCELLED OR NOT PICKED UP (DEBIT)

REASON: _____

SECTION 2 – ADJUSTMENT INFORMATION

PLAN MEMBER'S GREEN SHIELD ID. NUMBER	DEP NO.	SURNAME	FIRST NAME	DISPENSING DATE			DIN	RX NUMBER	NAME OF DRUG	NO OF MTHS	1 OR 2	QTY	GROSS AMOUNT	(COST + FEE)	REASON CODE
				Y	M	D									

 SIGNATURE OF PHARMACIST

 DATE

SECTION 3 – MAILING INSTRUCTIONS

PLEASE RETAIN COPIES FOR YOUR FILES AS CORRESPONDENCE PROVIDED 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)

PLEASE INDICATE ON MAILING ENVELOPE:

GREEN SHIELD CANADA
 P.O. BOX 1652, WINDSOR, ONTARIO N9A 7G5
 ATTENTION: DRUG DEPARTMENT

CUSTOMER SERVICE CENTRE 1-888-711-1119 or (519) 739-1133 FAX 519-739-6483 TOLL FREE FAX 1-866-797-6483
 greenshield.ca