GREEN SHIELD CANADA

PHARMACY CLAIM SUBMISSION FORM

SECTION 1 – PHARMACY INFORMATION

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

SECTION 2 – MANUAL CLAIM SUBMISSION

PLAN MEMBER'S GREEN SHIELD ID	DEP NO	SURNAME	FIRST NAME	DISPENSING DATE Y	M	D	DIN	NO SUB (1 OR 2)	QTY	RX NUMBER	DAY SUPPLY	COST	FEE	SS FEE / COB AMT	INTER-VENTION CODE	GROSS AMOUNT

SECTION 3 – COMPOUND CLAIM SUBMISSION

PLAN MEMBER'S GREEN SHIELD ID	DEP NO.	SURNAME	FIRST NAME	COMPOUND CODE	QTY	DAYS SUPPLY	RX NUMBER	DISPENSING DATE YEAR	MONTH	DAY	GROSS AMOUNT

INGREDIENTS	DIN	QUANTITY	COST
		TOTAL COST	

PROF. FEE ____________________

COMPOUND TIME ____________________

CHARGE PER MINUTE ____________________

TOTAL $ ____________________

NAME OF PHYSICIAN

____

SECTION 4 – AUTHORIZATION

I HEREBY CERTIFY THAT THE DRUGS CLAIMED HEREON HAVE BEEN PROVIDED TO THE PERSON(S) IDENTIFIED ABOVE

____________________ SIGNATURE OF PHARMACIST

____________________ DATE

SECTION 5 – 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

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
greenshield.ca