

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. #		Da	ate of Birth		
Surname	name First Name			YY	Y MM DD	
Mailing Address				Telephone No. ()		
ity 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	
			_			
Total Amount Claimed \$						
By signing this claim form and/or submitting actual receipts, 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 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. 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. 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. 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. Signature of Plan Member						
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 Medical Items, P.O. Box 1623, Windsor, ON N9A 7B3 Vision/Hospital Dept. P.O. Box 1615, Windsor, ON N9A 7J3 Professional Services, P.O. Box 1699, Windsor, ON N9A 7G6 Other Claims, P.O. Box 1606, Windsor, ON N9A 6W1 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.