

AUDIO CLAIM FORM

THIS CLAIM FORM MUST BE FILLED OUT FOR ALL PAY SUBSCRIBER CLAIMS.

PROVIDER			PATIENT			
PROVIDER NO.		TELEPHONE NO.	GREEN SHIELD IDENTIFICATION NO.			
NAME		NAME				
ADDRESS		ADDRESS				
CITY	PROV	POSTAL CODE	CITY	PROV	POSTAL CODE	
TO BE COMPLETED BY THE PATIENT/GUARDIAN 1) ARE THESE SERVICES REQUIRED DUE TO A WORK RELATED INJURY? YES ☐ NO ☐ 2) ARE THESE SERVICES REQUIRED DUE TO AN AUTOMOBILE ACCIDENT? YES ☐ NO ☐ 3) DO YOU HAVE ANY OTHER AUDIO COVERAGE? YES ☐ NO ☐ If yes, please provide insurance Company name _____ If other coverage is GreenShield, indicate Green Shield number _____. FOR ONTARIO RESIDENTS - A COPY OF THE ADP FORM MUST ACCOMPANY THIS CLAIM. IF THIS IS NOT AN ADP CLAIM, PLEASE EXPLAIN WHY AND PROVIDE A COPY OF THIS AUDIOGRAM. FOR ALL OTHER PROVINCES - PROVIDE COPY OF AUDIOGRAM.						
Hearing aid recommended by ENT ☐, Otolaryngologist ☐, Audiologist ☐, Family doctor ☐. Name: _____ (please provide name) Diagnosis (reason for aid): _____			Date of Service (pick-up date) ____ / ____ / ____ yy mm dd			
			CHARGES			
				LEFT AID	RIGHT AID	
				TOTAL CHARGES	TOTAL CHARGES	
			ACQUISITION COST			
			MOLD			
			OPTIONS (LIST)			
			DISPENSING FEE			
			SUBTOTAL			
			ADP/ Provincial Plan ALLOWANCE			
			TOTAL			
			REPAIR MANUFACTURER (COPY OF INVOICE REQUIRED)			
			REPAIR PROVIDER			
			OTHER: i.e. Batteries Returns			
PATIENT/GUARDIAN I UNDERSTAND THAT THE CHARGES LISTED IN THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY AGREEMENT BENEFITS. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE SUPPLIER FOR THE COST OF THOSE SERVICES. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS FORM.			PATIENT/GUARDIAN ONLY COMPLETE THIS SECTION ON THE DATE OF PICKUP, AND ONLY IF THIS FORM IS COMPLETED. I HEREBY ASSIGN MY BENEFITS PAYABLE FROM THIS CLAIM TO THE ABOVE NAMED PROVIDER AND AUTHORIZE PAYMENT DIRECTLY TO HIM.			THERE IS NO NEED TO ATTACH A RECEIPT IF THIS FORM HAS BEEN COMPLETED AND IF THIS AREA HAS BEEN SIGNED. THE CHARGES LISTED ON THIS CLAIM HAVE BEEN PAID IN FULL BY THE SUBSCRIBER. PLEASE PAY SUBSCRIBER FOR ELIGIBLE CHARGES.
SIGNATURE OF PATIENT /GUARDIAN			SIGNATURE OF PATIENT/GUARDIAN			
			SIGNATURE OF PROVIDER			

THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/SUBSCRIBER.
ALL CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS OF THE DATE OF SERVICE.