

VISION CARE CLAIM FORM

PROVIDER IDENTIFICATION			Date of Pick Up		
			Year	Month	Day
Provider No.					
Name			Optometrist ☐		
Address			Optician ☐		
City/Town		Prov.	Postal Code		
Signature		Telephone No.		Employer's Name:	
		()		()	

**P
A
T
I
E
N
T**

Green Shield No.		
Surname		Given Name
Address		Apt.
City	Prov.	Postal Code
Relationship to Subscriber	Date of Birth ____/____/____ Yr Mo Day	
Employer's Name:	Telephone No. ()	

Do you have other Vision Care Coverage? Yes ☐ No ☐

If Yes, Please Complete Policy No. _____
Name of Insurer or Plan _____

If Yes, either a copy of the payment statement or denial letter from the primary carrier must be attached.

Is this a W.S.I.B. claim? Yes ☐ No ☐

Subscriber's
Date of Birth Yr Mo Day

Spouse's
Date of Birth Yr Mo Day

Must Be Completed By Supplier in All Cases

New Prescription ☐ Yes Lenses Only ☐ Yes
 Safety Glasses ☐ Yes Post-Cataract Claim ☐ Yes
 If yes for post-cataract, does patient have a lens implant? Yes ☐ No ☐

Frame and Manufacturer		
Eye Size		
☐ Plastic	☐ Heat Hardened	☐ Chemically Hardened
BREAKDOWN OF EXTRA CHARGES: (EG. OVERSIZE, PHOTOGREY, CASE, ETC.)		TRANSFER ITEMS TO MISC. BELOW
MISCELLANEOUS	AMOUNT	
1. _____	\$	_____
2. _____	\$	_____
3. _____	\$	_____
TOTAL		\$ _____

Prescription Details

Sphere	Cylinder	Axis	Prism	Tint
R				(Colour & No.) 1 2
L				
Add Bifocal	Type of Bifocal	Add Trifocal	Type of Trifocal	
R		R		
L		L		

CONTACT LENSES:

A) CAN VISUAL ACUITY BE RESTORED TO AT LEAST 20/70 IN THE BETTER EYE WITH CONVENTIONAL EYE GLASSES? ☐ Yes ☐ No
B) CAN VISUAL ACUITY BE RESTORED TO AT LEAST 20/40 IN THE BETTER EYE WITH CONVENTIONAL EYE GLASSES? ☐ Yes ☐ No
C) ARE THEY MEDICALLY NECESSARY DUE TO KERATOCONUS, IRREGULAR ASTIGMATISM OR IRREGULAR CORNEAL CURVATURE? ☐ Yes ☐ No

(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 SUPPLIER _____

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 MY SUPPLIER FOR THE COST OF THOSE SERVICES. I AUTHORIZE RELEASE OF THE INFORMATION CONTAINED IN THIS FORM.

(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 SUPPLIER AND AUTHORIZE PAYMENT DIRECTLY TO THE SUPPLIER.

SIGNATURE OF PATIENT OR PARENT/GUARDIAN

SIGNATURE OF SUBSCRIBER

Actual Charges	Green Shield Only
Frame	
Eyeglass Lenses	
Fee	
Contact Lenses	
Misc. 1	
Misc. 2	
Misc. 3	
Eye Exam	
Total	
Patient Paid	
Balance to be Paid to Supplier	

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 dependants, 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 dependants to disclose and receive information about them that is used for these purposes. I understand that this information may be seen by the cardholder.