encon

Health Care Claim Form

Section 1 Plan Member Information

Please print clearly

Plan Member Surname		Identification No.	
Address	City	Province	Postal Code
Home Telephone No.	Work Telephone No.	Email Address	

Section 2 Patient Information (Only include names of patients with receipts attached.)

First Name	Last Name	Dependent No.	Date of Birth (yyyy/mm/dd)
			Date of Birth (yyyy/mm/dd)
			Date of Birth (yyyy/mm/dd)

Section 3 Mandatory Declaration

1. Are any of the expenses being claimed covered by another group insurance plan? ❑ No ❑ Yes
   If yes, complete the following information about the person who is the MEMBER under the other plan: (If claiming co-ordination of benefits, please provide alternate carrier's explanation of benefits)
   Other Member's Name ______________________________
   If other coverage is Green Shield, indicate ID No.: ______________
2. Are any of the expenses being claimed due to:
   A. A work related injury? ❑ No ❑ Yes If yes, date of injury ____________ (yyyy/mm/dd)
   B. A motor vehicle accident? ❑ No ❑ Yes If yes, date of accident ____________ (yyyy/mm/dd)

Section 4 Claims

Patient's First Name	Dependent No.	Professional's/ Supplier's Name and Provider No. (if available)	Date of Claim (yyyy/mm/dd)	Type of Expense	Total Amount Charged Per Visit/Item

Section 5 Authorization

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.

Plan Member Signature ______________________ Date (yyyy/mm/dd) ______________

Section 6 Mailing Instructions

Professional Services	**Medical Items**	**Other Claims**	**Drug Dept.**	**Vision and Accommodation**
P.O. Box 1699	P.O. Box 1623	P.O. Box 1606	P.O. Box 1652	P.O. Box 1615
Windsor, ON	Windsor, ON	Windsor, ON	Windsor, ON	Windsor, ON
N9A 7G6	N9A 7B3	N9A 6W1	N9A 7G5	N9A 7J3

CLAIMS SERVICE CENTRE 1-888-711-1119

For claims requiring pre-authorization or specific claim forms, please request from our Claims Service Centre.

Please attach all original paid receipts, prescription and authorized forms.

Please retain copies for your files as original receipts will not be returned.

The intentional falsification, misrepresentation or omission of information on or relating to this claim constitutes fraud.

ENCON Group Inc.

www.encon.ca

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