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. #**	**Date of Birth** _____/_____/_____ YY MM DD
Surname	**First Name**	
Mailing Address		**Telephone No. ( )**
City	**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 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.

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
Prof. 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

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.