Green Shield CANADA

AUDIO CLAIM FORM

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: _____ IF OTHER COVERAGE IS GREEN SHIELD, INDICATE GREEN SHIELD NUMBER

_____ Insurer's Company Name

Date of Service (pick-up date) _____/_____/_____ yy mm dd

Hearing aid recommended by ENT ☐ , **Otolaryngologist** ☐ ,

Audiologist ☐ , **Family doctor** ☐ , **(please provide name)**

Name: _____

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.

DESCRIPTION OF HEARING AID

MANUFACTURER OR SUPPLIER	ADP CATALOGUE #
	SERIAL #

RECEIVER TYPE (PLEASE CHECK)

BTE	_ R-70410 _ L-70400	_ R-70910 _ L-70900	_ R-70735 _ L-70730
ITE	_ R-70610 _ L-70600	_ R-70810 _ L-70800	_ R-70725 _ L-70720
ITC	_ R-70510 _ L-70500	_ R-70925 _ L-069829	_ R-70710 _ L-70700
CIC	_ R-70710 _ L-70700		

CHARGES

	LEFT AID TOTAL CHARGES	RIGHT AID TOTAL CHARGES
ACQUISITION COST		
MOLD		
OPTIONS (LIST)		
DISPENSING FEE		
SUBTOTAL		
ADP/ Provincial Plan ALLOWANCE		
TOTAL		
REPAIR (COPY OF INVOICE REQUIRED) — MANUFACTURER		
REPAIR (COPY OF INVOICE REQUIRED) — PROVIDER		
OTHER: i.e. Batteries Returns		

THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/SUBSCRIBER.

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.

SIGNATURE OF PATIENT /GUARDIAN

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.

SIGNATURE OF PATIENT/GUARDIAN

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 PROVIDER

GREEN SHIELD CANADA , P.O. BOX 1699, WINDSOR, ONTARIO N9A 7G6
ATTENTION: EHS DEPARTMENT - **CUSTOMER SERVICE CENTRE** **1-888-711-1119** or **(519) 255-1133**