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Health Care Spending Account Claim Form

This form should be used when submitting claims under your Health Care Spending Account for eligible expenses which are not covered (or not covered in full) by your health or dental plan.

Section 1 Plan Member Information

Please print clearly

Last Name | First Name | Identification No.

Address | City | Province | Postal Code

Date of Birth (yyyy/mm/dd) | Home Telephone No. | Work Telephone No. | Email Address

Do you have any other Group Insurance coverage that may include these services as benefits?

❑ No ❑ Yes

If yes, please provide Insurance Company name

Section 2 Coverage Details

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 Number ____________________ 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, claims will be paid according to Box 1.

Health Care Expenses

Patient's First Name	Dependent No.	Description of Expense	Date of Expense (yyyy/mm/dd)	Amount
			Total Amount Claimed	

Section 3 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 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.

Plan Member Signature | Date (yyyy/mm/dd)

Section 4 Mailing Instructions

Mail this form and enclosures to: Green Shield Canada, Attention Health Care Spending Account to the appropriate department address.

Professional Services
P.O. Box 1699
Windsor, ON
N9A 7G6

Medical Items
P.O. Box 1623
Windsor, ON
N9A 7B3

Drug Dept.
P.O. Box 1652
Windsor, ON
N9A 7G5

Vision and Accommodation
P.O. Box 1615
Windsor, ON
N9A 7G3

Dental Dept.
P.O. Box 1608
Windsor, ON
N9A 7G1

CLAIMS SERVICE CENTRE 1-888-711-1119

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.