encon

Medical Travel Benefit Claim Form
Certification of Necessity

Section 1 Plan Member Information

Please print clearly

Name of Plan Member | Identification No.

Address

Home Telephone | Work Telephone | Email

Section 2 Patient Information

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

Section 3 Mandatory Declaration

1. Do you have any other group insurance coverage that may include these services as benefits? ○ Yes ○ No
   If yes, please provide the name of the insurance company
   If other coverage is with Green Shield Canada, indicate other Green Shield Canada Identification No. _____
2. Do you want to co-ordinate this claim with your other Green Shield Canada coverage? ○ Yes ○ No
3. Is treatment due to a motor vehicle accident? ○ Yes ○ No If yes, date of accident _____ (yyyy/mm/dd)
4. Is treatment required due to a work-related injury? ○ Yes ○ No If yes, date of injury _____ (yyyy/mm/dd)
   If yes, provide WCB/WSIB No.

Section 4 To Be Completed by Physicians

Referring Physician's Statement

Name of Patient | Date of Birth (yyyy/mm/dd)

Name and address of hospital or medical facility to which patient is referred

Please indicate what type of services are required

Name of Referring Physician

Please sign here Referring Physician Signature | Date (yyyy/mm/dd)

Receiving Physician's Statement

Date of appointment(s) (yyyy/mm/dd)

Name of Receiving Physician

Please sign here Receiving Physician Signature | Date (yyyy/mm/dd)

Continued on next page

Section 5 Mileage Declaration

Please print clearly

1. If you are claiming mileage reimbursement, please complete the following:

   Travelling from (City/Town) _____

   Travelling to (City/Town) _____

   Total Round Trip Kilometers _____ km

Note: If you are claiming transportation costs for airline, train or bus fare and/or hotel accommodation, you must attach your original receipts.

Section 6 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.

Please sign here

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

Section 7 Mailing Instructions

Mail form and detailed tickets and/or receipts to: Green Shield Canada
Attention: EHS Department
P.O. Box 1699
Windsor ON N9A 7G6

The Plan Member is responsible for any costs related to the completion of this form.