

AUDIO CLAIM FORM

THIS CLAIM FORM MUST BE FILLED OUT FOR ALL PAY SUBSCRIBER CLAIMS.

PROVIDER		PATIENT			
PROVIDER NO. TELEPHONE NO.		GREEN SHIELD IDENTIFICATION NO.			
NAME		NAME			
ADDRESS		ADDRESS			
CITY PROV POS	STAL CODE	CITY		PROV	POSTAL CODE
2) ARE THESE SERVICES REQUIRED DUE TO AN AUTOMOBILE ACCIDENT? YE			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.		
Hearing aid recommended by ENT □, Otolaryngologist □, Audiologist □, Family doctor □,		Date of Service (pick-up date) /////////			
Name:		CHARGES			
(please provide name) Diagnosis (reason for aid):				LEFT AID	RIGHT AID
				TOTAL CHARGES	TOTAL CHARGES
		ACQUISITION COST			
DESCRIPTION OF HEARING AID		MOLD			
RECEIVER TYPE (Please Check) Conventional Programmable Digital		OPTIONS (LIST)			
BTE R-70410 R-70910 L-70400 L-70900	R-70735 L-70730	DISPENSING FEE			
ITE R-70610 R-70810 L-70600 L-70800	R-70725 L-70720	SUBTOTAL			
ITC R-70510 R-70925 L-70500 L-70920	R-70710 L-70700	ADP / Provincial Plan ALLOWANCE			
CIC R-70710 L-70700		TOTAL			
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.		REPAIR MANUFAC			
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.		OTHER: i.e. Batte Retu	eries urns		
THIS CLAIM MAY NOT BE COVERED BY OR MAY EXCEED MY AGREEMENT BENEFITS.DATE OF PICKUP, AND COMPLETED.IUNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE TO THE SUPPLIER FOR THEI HEREBY ASSIGN N FROM THIS CLAIM T		N HIS SECTION ON THE D ONLY IF THIS FORM IS MY BENEFITS PAYABLE TO THE ABOVE NAMED AUTHORIZE PAYMENT		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.	
THIS FORM. SIGNATURE OF PATIENT /GUARDIAN SIGNATURE OF PATIENT/		GUARDIAN SIGNATURE OF PROVIDER		IER	

THE COST, IF ANY, OF OBTAINING THIS INFORMATION IS AT THE EXPENSE OF THE PATIENT/SUBSCRIBER. ALL CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS OF THE DATE OF SERVICE.