PHARMACY ADJUSTMENT FORM

SECTION 1 – PHARMACY INFORMATION

PROVIDER NUMBER	PROVIDER PHONE NUMBER	CONTACT PERSON'S NAME

NAME OF PHARMACY

ADDRESS

CITY	PROVINCE	POSTAL CODE

REASON CODES FOR ADJUSTMENT

1 – PRODUCT SELECTION CODE MISSING – PLEASE INDICATE: 1 OR 2
2 – WRONG QUANTITY
3 – MULTIPLE SIZE (i.e.: 1ML, 5ML, 10ML – INDICATE PACKAGE SIZE DISPENSED)
4 – NO OF MONTHS SUPPLY
5 – CHANGE IN GROSS AMOUNT (COST + FEE)
6 – WRONG DIN USED
7 – RX CANCELLED OR NOT PICKED UP (DEBIT)

REASON: _____

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SECTION 2 – ADJUSTMENT INFORMATION

PLAN MEMBER'S GREEN SHIELD ID. NUMBER	DEP NO.	SURNAME	FIRST NAME	DISPENSING DATE Y	M	D	DIN	RX NUMBER	NAME OF DRUG	NO OF MTHS	1 OR 2	QTY	GROSS AMOUNT	(COST + FEE)	REASON CODE

_____ SIGNATURE OF PHARMACIST

_____ DATE

SECTION 3 – MAILING INSTRUCTIONS

PLEASE RETAIN COPIES FOR YOUR FILES AS CORRESPONDENCE PROVIDED WILL NOT BE RETURNED
ALL CLAIMS MUST BE SUBMITTED WITHIN 12 MONTHS OF THE DATE OF SERVICE (UNLESS OTHERWISE STATED IN YOUR BENEFIT PLAN DOCUMENTATION)

PLEASE INDICATE ON MAILING ENVELOPE:

GREEN SHIELD CANADA
P.O. BOX 1652, WINDSOR, ONTARIO N9A 7G5
ATTENTION: DRUG DEPARTMENT

CUSTOMER SERVICE CENTRE 1-888-711-1119 or (519) 739-1133 FAX 519-739-6483 TOLL FREE FAX 1-866-797-6483
greenshield.ca