PHARMACY CLAIM SUBMISSION FORM

SECTION 1 PHARMACY INFORMATION

PROVIDER NUMBER | PROVIDER PHONE NUMBER | CONTACT PERSON'S NAME

NAME OF PHARMACY

ADDRESS

CITY | PROVINCE | POSTAL CODE

SECTION 2 – MANUAL CLAIM SUBMISSION

CERTIFICATE NUMBER	SURNAME	FIRST NAME	DISPENSING DATE Y	M	D	DIN	NO SUB (1 OR 2)	QTY	RX NUMBER	DAY SUPPLY	COST	FEE	SS FEE / COB AMT	INTER-VENTION CODE	GROSS AMOUNT

SECTION 3 – COMPOUND CLAIM SUBMISSION

CERTIFICATE NUMBER	SURNAME	FIRST NAME	COMPOUND CODE	QTY	DAYS SUPPLY	RX NUMBER	DISPENSING DATE YEAR MONTH DAY	GROSS AMOUNT

INGREDIENTS	DIN	QUANTITY	COST
		TOTAL COST	

PROF. FEE

COMPOUND TIME

CHARGE PER MINUTE

TOTAL $

NAME OF PHYSICIAN

SECTION 4 – AUTHORIZATION

I HEREBY CERTIFY THAT THE DRUGS CLAIMED HEREON HAVE BEEN PROVIDED TO THE PERSON(S) IDENTIFIED ABOVE

SIGNATURE OF PHARMACIST | DATE

SECTION 5 – 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