

GreenShield Cares' EMP External Referral

Fax this form to: 519-754-0757

PATIENT INFORMATION

NAME:		
PHONE:	EMAIL:	
ADDRESS:		
CITY:	PROV:	POSTAL CODE:
DOB:		
Special Notes (referral urgency, end date for current benefits, date prescription needs to be renewed by etc.):		

REFERRING HEALTHCARE PROVIDER

NAME:	
PHONE:	FAX #:
SIGNATURE:	DATE:

Thank you for your referral! GRCHC will assess your patient's eligibility for the GreenShield Cares Essential Medicines Program. If eligible, we will assist your patient with the application process to access a prescription drug benefit plan at no cost.

For questions, please call **519-732-0412**, Monday to Friday, between 8:00 a.m. and 4:00 p.m.