PACIFIC BLUE CROSS

First Nations Health Authority
Health through wellness

DO NOT WRITE IN THIS SPACE

CLIENT HEALTH CLAIM/PRE-DETERMINATION FORM

Ø PLEASE DO NOT STAPLE

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | pac.bluecross.ca

CHOOSE ONE: ☐ Pre-determination — Please enclose a quote
☐ Claim — Please enclose an invoice or receipt

PART 1 — CLIENT INFORMATION

Policy number	Status number
40000	
Client's first name	Client's last name
Street address	
City	Province	Postal code
Phone number (10 digits)	Email

PART 2 — PROVIDER INFORMATION

Provider ID number	
Provider's name	
Street address	
City	Province	Postal code
Phone number (10 digits)	Email

PART 3 — OTHER INSURANCE COVERAGE

Complete this section if you or your spouse are covered under another plan. Please see the special instructions for coordination of benefits on page 2.

Other insurance coverage ☐ Pacific Blue Cross ☐ Other insurer: _____	Coverage start date (mm-dd-yyyy)
Client's policy number	Client's ID number	Plan member ☐ Same as above ☐ Spouse	Cancellation date if applicable (mm-dd-yyyy)
Spouse's first name if spouse's plan	Spouse's last name if spouse's plan	Employment status of spouse ☐ Full-time ☐ Part-time ☐ Retiree ☐ Student	Spouse's birthdate (mm-dd-yyyy)

PART 4 — INFORMATION ABOUT THE CLAIM

DESCRIPTION	QUANTITY	TOTAL EXPENSES
		$
		$
		$
		$
	GRAND TOTAL	$ 0.00

1. Are the expenses being claimed: The result of a workplace injury? (i.e., WorkSafeBC) ☐ Yes ☐ No If yes, date of injury: _____
   The result of a motor vehicle or other accident? ☐ Yes ☐ No If yes, date of accident: _____
2. Is the client seeking damages from a 3rd party? ☐ Auto ☐ WorkSafeBC ☐ Other: _____
3. Is this a vision claim? ☐ Yes ☐ No If yes, a copy of the vision exam results must be included.

If yes to any of these questions, please see page 2 of this form.

PART 5 — CLIENT CONSENT AND DECLARATION

IMPORTANT: This section must be signed before submitting your claim.

I declare that all information in this form is true and complete. I understand Pacific Blue Cross will use the personal information on this form, and any other personal information they hold about me and my eligible dependents to determine eligibility for benefits coverage. I acknowledge and agree that personal information about me and my eligible dependents may be collected, used and exchanged between Pacific Blue Cross and any other person or organization related to this claim or the administration of my benefit plan. This includes health care professionals, institutions, investigative agencies, insurers/re-insurers, government organizations or regulatory bodies. I acknowledge disclosure of my personal information by Pacific Blue Cross to my plan sponsor when required or permitted by law or pursuant to its contractual obligations under my benefit plan. I understand I may revoke this consent at any time and acknowledge that should I do so, this claim may not be considered.

If there is overpayment, I authorize its recovery from any amount payable to me under my benefit plan(s).

I have read and understand this Client Consent and Declaration and agree that a photocopy or digital version shall be as valid as the original and may remain in effect for the continued administration of this plan.

Client's signature **X**	Date (mm-dd-yyyy)

Place your receipts loose and flat in the envelope — no staples, paperclips or tape. Also no cashier or Interac receipts.

TIPS FOR PREPARING A CLAIM

1. If you are submitting a claim, please ensure that all sections of the form are filled in completely. Additionally, all claims must be submitted with original invoices or paid-in-full receipts which show:
   - Claimant's first and last name
   - Description of item(s) purchased or service(s) rendered
   - Date of each purchase or service
   - Amount charged for each purchase or service
   - Name, address and phone number of supplier or provider
   - Don't forget to sign *Part 5 — Client Consent and Declaration* before you submit the claim
2. If you are submitting a pre-determination, please enclose a quote as well as any required supporting documentation.
3. Please keep photocopies of any documentation (including quotes, invoices and receipts) submitted. Pacific Blue Cross does not return originals.
4. Place any documentation (including quotes, invoices or receipts) loose and flat in the envelope — no staples, paperclips or tape.
5. Submit only one of each official quote, invoice or receipt.
6. Please be aware that some benefits require the submission of a doctor's note. However, Pacific Blue Cross does not reimburse the cost associated with obtaining a doctor's note.

INCOMPLETE FORMS MAY DELAY THE PROCESSING OF YOUR CLAIM.

PACIFIC BLUE CROSS®

MAIL YOUR CLAIM
Pacific Blue Cross
PO Box 7000, Vancouver, BC V6B 4E1

DROP IT OFF
4250 Canada Way
Burnaby, BC V5G 4W6

QUESTIONS?
604 419-2000
Toll-free: 1 877 PAC-BLUE

pac.bluecross.ca

SPECIAL INSTRUCTIONS

COORDINATION OF BENEFITS
If the client has other insurance coverage, please enclose the Explanation of Benefits from the other carrier.

WORKPLACE, AUTOMOBILE OR OTHER ACCIDENTS
If the client's claim is the result of a workplace or motor vehicle accident or an incident where third party liability may be involved, please instruct them to complete and submit the appropriate *Accident or Injury Reimbursement Agreement Form*. All forms are available on our website.

If the client's motor vehicle accident occurred on or after November 9, 2018, the client must contact ICBC directly for consideration of these expenses as advances are no longer permitted.

BENEFITS WITH SPECIAL CLAIMING CRITERIA
Please refer to PBC's online Member Profile to assess whether the benefit you would like to submit has special claiming criteria (e.g. orthotics). Be sure to submit the appropriate documentation.

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