PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

STANDARD HEALTH CLAIM FORM

⊘ 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 — MEMBER INFORMATION

Policy number	ID number	Name of plan, company name or Plan sponsor (if applicable)	
First name	Last name	Employment status ☐ Full-time ☐ Part-time ☐ Retiree ☐ Student	Daytime phone number (10 digits)
Street address	City	Province	Postal code / New address? ☐ Yes

PART 2 — 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)
Member's policy number	Member'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 3 — INFORMATION ABOUT YOUR CLAIM(S)

Please provide the first name and birthdate for each eligible person with a claim. For each person, add up all receipts and provide the total amount of their expenses.

If any expenses are the result of a medical emergency outside your province, visit Member Profile to download an *Emergency Out-of-Province Claim Form*.

Remember to enclose all supporting documentation and original receipts. You can mail your claim to us or drop it off at our Burnaby office.

FIRST NAME	BIRTHDATE	TOTAL EXPENSES
	(mm-dd-yyyy)	$
	(mm-dd-yyyy)	$
	(mm-dd-yyyy)	$
	(mm-dd-yyyy)	$
	GRAND TOTAL	$

If yes to either of the following questions, please complete an *Accident or Injury Reimbursement Agreement Form* available on Member Profile.

1. Are the expenses you're claiming: The result of a workplace injury? (i.e., WorkSafeBC) ☐ Yes ☐ No
   The result of a motor vehicle or other accident? ☐ Yes ☐ No
2. Are you seeking damages from a 3rd party? ☐ Auto ☐ WorkSafeBC ☐ Other: _____

PART 4 — HEALTH SPENDING ACCOUNT (HSA): Complete only if you have an HSA, see page 2 for more information

If applicable, apply any unpaid balance(s) to your HSA? ☐ Yes ☐ No

PART 5 — MEMBER 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 and pay claims. 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 I am making a claim under my Health Spending Account (where applicable), I acknowledge that the person(s) for whom I am making a claim are eligible and I accept full responsibility to ensure all expenses submitted for payment from my Health Spending Account are allowable medical expenses as defined under the Canadian Income Tax Act. I understand I am responsible for payment of any taxes that arise from reimbursement of these expenses. I also agree my plan sponsor may have access to a summary of the total amounts claimed by me for the purposes of tax or administrative reporting.

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 Member 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.

Member'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 YOUR CLAIM

1. Your policy and identification numbers are on your Pacific Blue Cross ID card.
2. All claims must be submitted with original, 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
   - Provider registration number (if applicable)
3. Please keep photocopies of your receipts. Pacific Blue Cross does not return original receipts.
4. Place your receipts loose and flat in the envelope — no staples, paperclips or tape.
5. Submit only one of each official receipt. Do not include any cashier or Interac receipts.
6. Not all benefit coverage is the same. Visit Member Profile to view benefits covered by your plan and your claiming deadline.
7. Don't forget to sign *Part 5 — Member Consent and Declaration* before you submit your claim.

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

Only complete *Part 2 — Other Insurance Coverage* if you or your spouse are covered under another plan. Send your claim to your plan first. When you receive your claim statement, send a copy of that statement plus copies of your receipts to your other plan to claim any unpaid amount.

If you have claims for your children, send those claims first to the plan of the parent whose birthday falls earlier in the year.

Learn more about coordination of benefits at pac.bluecross.ca.

WORKPLACE, AUTOMOBILE OR OTHER ACCIDENTS

If your claim is a result of a workplace or automobile accident or an incident where third party liability may be involved, please complete and submit an *Accident or Injury Reimbursement Agreement Form* in addition to this *Standard Health Claim Form*. All forms are available on Member Profile.

ORTHOTICS AND ORTHOPEDIC SHOES

If this benefit is covered by your plan, visit Member Profile to view a list of special claiming criteria and to download an additional form (either the *Custom Foot Orthotics Claiming Checklist* or the *Custom Orthopedic Shoe Claiming Checklist*) which must be submitted with your claim.

HEALTH SPENDING ACCOUNTS

If this feature is part of your coverage, you can choose to apply any unpaid balance of your claim to your Health Spending Account.

The Canada Revenue Agency can answer your questions about which medical expenses meet the Income Tax Act requirements — call toll-free 1 800 959-8281. A list of eligible expenses can also be found at cra-arc.gc.ca.

OUT-OF-PROVINCE EXPENSES

If any of your expenses are due to a medical emergency that happened while you were outside of the province where you live, visit Member Profile to download an *Emergency Out of Province Claim Form*.