PACIFIC BLUE CROSS

First Nations Health Authority
Health through wellness

DO NOT WRITE IN THIS SPACE

PROVIDER MENTAL HEALTH CLAIM FORM

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | Fax: 604 677-0277 | pac.bluecross.ca

PART 1 — CLIENT INFORMATION

Policy number	Status number (Non-status clients contact FNHA to obtain ID number)	Client's birthdate (mm-dd-yyyy)
40000		

Client's first name	Client's last name

Street address

City	Province	Postal code

Phone number (10 digits)	Email

PART 2 — PROVIDER INFORMATION

Practitioner ID number

Practitioner's name	Provider's name

Street address

City	Province	Postal code

Phone number (10 digits)	Email	GST#

PART 3 — INFORMATION ABOUT THE CLAIM

Please select applicable program:
☐ Mental Wellness and Counselling Program
☐ Indian Residential Schools Resolution Health Support Program
☐ Missing and Murdered Indigenous Women and Girls Health Support Services Program
☐ Indian Day School Health Support Services Program

SESSION TYPE		SESSION DATE	SESSION DURATION (BILL IN 15 MIN. INCREMENTS. EX. 1 HOUR 15 MIN IS 1.25)	5% GST (GST# REQUIRED)	FNHA HOURLY RATE (INCLUDE GST IF APPLICABLE)
☐ Individual ☐ Group	☐ In-Person ☐ Telehealth/Online	(mm-dd-yyyy)		☐	$
☐ Individual ☐ Group	☐ In-Person ☐ Telehealth/Online	(mm-dd-yyyy)		☐	$
☐ Individual ☐ Group	☐ In-Person ☐ Telehealth/Online	(mm-dd-yyyy)		☐	$
☐ Individual ☐ Group	☐ In-Person ☐ Telehealth/Online	(mm-dd-yyyy)		☐	$
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☐ Individual ☐ Group	☐ In-Person ☐ Telehealth/Online	(mm-dd-yyyy)		☐	$
☐ Individual ☐ Group	☐ In-Person ☐ Telehealth/Online	(mm-dd-yyyy)		☐	$
☐ Individual ☐ Group	☐ In-Person ☐ Telehealth/Online	(mm-dd-yyyy)		☐	$

PART 4 — CERTIFICATION

I certify that the counselling services rendered were to the named client and that the client was present at each appointment.
I have verified with the client that they have not become eligible for coverage under any other insurance plan or public program.
I confirm that I am only billing for one client, even if more than one person attended the above session(s).
I acknowledge that all claims submitted to PBC may be subject to audit by their Audit, Investigations and Quality Assurance Department, as outlined in the PBC Health Reference Guide.
I confirm that the client has signed the PBC Pay Provider Authorization Form, in accordance with the PBC Health Reference Guide.

Provider's signature	Date (mm-dd-yyyy)
X	

Payment requests older than one (1) year from the service provision date will not be accepted.

TIPS FOR PREPARING A CLAIM

1. Provider is the Payee. Practitioner is the person providing services.
2. Provider Signature section is signed by the person providing the services.
3. If you are submitting a claim, please ensure that all sections of the form are filled in completely.

INCOMPLETE FORMS MAY DELAY THE PROCESSING OF YOUR CLAIM.

Want to see your claims results immediately? Please sign up on providernet.ca.

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