PACIFIC BLUE CROSS

First Nations Health Authority
Health through wellness

DO NOT WRITE IN THIS SPACE

PROVIDER HEALTH CLAIM/PRE-DETERMINATION 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

PART 1 — CLIENT INFORMATION

Policy number	Status 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

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	Coverage start date (mm-dd-yyyy)
☐ Pacific Blue Cross ☐ Other insurer: ______	

Client's policy number	Client's ID number	Plan member	Cancellation date if applicable (mm-dd-yyyy)
		☐ Same as above ☐ Spouse	

Spouse's first name if spouse's plan	Spouse's last name if spouse's plan	Employment status of spouse	Spouse's birthdate (mm-dd-yyyy)
		☐ Full-time ☐ Part-time ☐ Retiree ☐ Student	

PART 4 — INFORMATION ABOUT THE CLAIM

DESCRIPTION	DATE OF SERVICE	DIN/PIN/ITEM CODE	PreD ID (FOR CLAIMS ONLY)	QUANTITY	DAY SUPPLY	PROVIDER ACQUISTION COSTS	MARK-UP	TOTAL EXPENSES
	(mm-dd-yyyy)					$	$	$
	(mm-dd-yyyy)					$	$	$
	(mm-dd-yyyy)					$	$	$
	(mm-dd-yyyy)					$	$	$
	(mm-dd-yyyy)					$	$	$
	(mm-dd-yyyy)					$	$	$
	(mm-dd-yyyy)					$	$	$
	(mm-dd-yyyy)					$	$	$
							GRAND TOTAL	$

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. Please outline the diagnosis and attach all required documentation per the Fee Supplement (for providers only):

______

______

______

______

______

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

PART 5 — CLIENT CONSENT AND DECLARATION

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

In making this assignment regarding the attached invoice, I understand and agree that any balance not covered by the Extended Health Benefits Plan(s) listed above is/are my/our responsibility. Monies paid by Pacific Blue Cross on behalf of a client to a provider must be returned to Pacific Blue Cross if the item/service cost is refunded. 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

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. I authorize my physician to release my personal information to Pacific Blue Cross to obtain approval for prescription benefit.

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

PART 6 — PROVIDER SIGNATURE

I hereby declare that the items/services billed have been provided to the client named above. The information provided on this form is true and complete to the best of my knowledge.

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

TIPS FOR PREPARING A CLAIM/PRE-DETERMINATION

1. If you are submitting a claim, please ensure that all sections of the form are filled in completely.
2. Don't forget to include the required signatures under Part 5 and Part 6.
3. If you are submitting a pre-determination, please enclose a quote as well as any required supporting documentation.
4. Please keep photocopies of any documentation (including quotes, invoices and receipts) submitted. Pacific Blue Cross does not return originals.
5. Place any documentation (including quotes, invoices or receipts) loose and flat in the envelope — no staples, paperclips or tape.
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.
7. Please provide the total acquisition/manufacturer costs and mark-up for all units of the item dispensed. Section must be completed when the coverage requested exceeds amounts outlined in the Fee Supplement. Acquisition cost and mark-up are not required for Drugs or Vision claims.

INCOMPLETE FORMS MAY DELAY THE PROCESSING OF YOUR CLAIM.

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 the FNHA Fee Schedule to assess whether the benefit you would like to submit has special claiming criteria (e.g. orthotics). Be sure to submit the appropriate documentation as required.

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