PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

BRITISH COLUMBIA Ministry of Social Development and Poverty Reduction

VISION FORM

Mail: PO Box 65339 STN F, Vancouver, BC V5N 5P3 | Drop it off: 4250 Canada Way, Burnaby, BC | pac.bluecross.ca

CHOOSE ONE: ☐ PREDETERMINATION/PREAUTHORIZATION — signatures not required
☐ CLAIM — signatures required

PART 1 — CLIENT INFORMATION

Client's last name	Client's first name	Birthdate (mm-dd-yyyy)	PHN (Personal Health Number)

Street address	City	Province	Postal code

I certify that I have received the goods/services, and that I am authorized to purchase for the above named person.

Authorized purchaser's signature	Date (mm-dd-yyyy)
X	

PART 2 — OTHER INSURANCE COVERAGE

Complete this section if you 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 ☐ Parent/Guardian	Cancellation date if applicable (mm-dd-yyyy)
First name of other plan holder	Last name of other plan holder	Employment status of other plan holder ☐ Full-time ☐ Part-time ☐ Retiree ☐ Student	Other plan holder's birthdate (mm-dd-yyyy)

PART 3 — OPTOMETRIST/OPHTHALMOLOGIST INFORMATION

This section must be completed if the submission is for an eye exam OR the provider location is owned by optometrists or ophthalmologists.

Practitioner number	☐ I confirm that the eye examination is not eligible for coverage under the Medicare Protection Act
Name	

PART 4 — VISION PRODUCTS AND SERVICES

DATE	FEE CODE	DESCRIPTION	AMOUNT
(mm-dd-yyyy)			$
(mm-dd-yyyy)			$
(mm-dd-yyyy)			$
(mm-dd-yyyy)			$
(mm-dd-yyyy)			$
		TOTAL CLAIM (OPTIONAL)	$ 0

PART 5 — PRESCRIPTION INFORMATION

Regardless of whether you are providing/replacing one or both lenses, please enter the full prescription.

Examination date (mm-dd-yyyy) — Required: _____

	SPH	CYL	AXIS	PRISM	BASE	
RIGHT						☐ Plano ☐ Balance
LEFT						☐ Plano ☐ Balance
ADD RIGHT		**ADD LEFT**				

☐ Bifocal ☐ Trifocal ☐ Readers ☐ Distance

Comments/essential medical reasons for additions:

_____

_____

_____

PART 6 — PAYMENT INFORMATION

Provider number	Phone number	Name

Street address	City	Province	Postal code

I hereby declare that the goods/services billed to the province of BC Ministry of Social Development and Poverty Reduction have been provided to the person authorized above. I acknowledge that I have received a valid and signed Ministry Pay Provider Authorization Form from the named client and I am authorized to receive payment from Pacific Blue Cross for this claim.

Provider signature	Date (mm-dd-yyyy)
X	

SPECIAL INSTRUCTIONS

COORDINATION OF BENEFITS

Only complete *Part 2 — Other Insurance Coverage* if you have primary coverage under another plan. To claim any unpaid amounts, when you receive your claim statement from the other plan, submit a copy of their statement along with this claim form.

PACIFIC BLUE CROSS®

MAIL YOUR CLAIM
Pacific Blue Cross
PO Box 65339 STN F, Vancouver, BC
V5N 5P3

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

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

pac.bluecross.ca