PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

BRITISH COLUMBIA | Ministry of Social Development and Poverty Reduction

# HEARING INSTRUMENT 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 |
|---|---|---|---|
| | | | |

If you ("the client") currently reside in a long term residential care facility, hospital or special care facility, include the name of the facility or residence:

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<br>☐ Pacific Blue Cross ☐ Other insurer: _____ | | | Coverage start date (mm-dd-yyyy) |
|---|---|---|---|
| Member's policy number | Member's ID number | Plan member<br>☐ 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<br>☐ Full-time ☐ Part-time ☐ Retiree ☐ Student | Other plan holder's birthdate (mm-dd-yyyy) |

Are the billed hearing expenses eligible for coverage under WorkSafeBC, Veterans Affairs Canada or any other available benefit? ☐ Yes ☐ No

## PART 3 — SERVICE INFORMATION

| DATE (CLAIMS ONLY) | EAR | DESCRIPTION | AMOUNT |
|---|---|---|---|
| (mm-dd-yyyy) | ☐ Left ☐ Right | | $ |
| (mm-dd-yyyy) | ☐ Left ☐ Right | | $ |
| (mm-dd-yyyy) | ☐ Left ☐ Right | | $ |
| (mm-dd-yyyy) | ☐ Left ☐ Right | | $ |
| (mm-dd-yyyy) | ☐ Left ☐ Right | | $ |
| (mm-dd-yyyy) | ☐ Left ☐ Right | | $ |

## PART 4 — PAYMENT INFORMATION

| PBC 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's signature | Date (mm-dd-yyyy) |
|---|---|
| X | |

**Complete the next page if the request is for a new hearing instrument, repairs or replacement.**

**For cochlear implants, please include a letter of medical necessity from the attending physician.**

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## PART 5 — HEARING INSTRUMENTS

Please answer the following based on the audiogram. If answered, it is not required to submit the audiogram, except on request.

### HEARING TEST

Date of hearing test (mm-dd-yyyy): _____

**Symptoms** (include the client's primary complaints):

**Communication Status:**

| Left ear | Right ear |
|---|---|
| Otoscopic examination: | Otoscopic examination: |
| Level of hearing loss — Choose only one: ☐ Mild ☐ Moderate ☐ Severe | Level of hearing loss — Choose only one: ☐ Mild ☐ Moderate ☐ Severe |
| Additional comments from hearing test: | Additional comments from hearing test: |

### LISTENING/HEARING ENVIRONMENT

**Does the client's listening environment primarily involve (choose only one):**

A ☐ One-on-one conversations with little background noise
B ☐ Small group conversations with little background noise
C ☐ One-on-one and small group conversations with moderate background noise
D ☐ One-on-one and small group conversations with extensive background noise

## PART 6 — REPAIRS OR REPLACEMENT (if applicable)

Has the warranty been applied to this or a previous repair or replacement? ☐ Yes ☐ No If yes, please provide date (mm-dd-yyyy): _____

If no, please provide the reason that warranty does not apply:

## PART 7 — SUPPLIES

Please provide a description of the supplies being purchased:

## PART 8 — ADDITIONAL INFORMATION

Please provide any additional comments to support the need for the specific hearing device, repair or replacement claimed:

# 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.