PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

BRITISH COLUMBIA | Ministry of Social Development and Poverty Reduction

# PAY PROVIDER AUTHORIZATION

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

**PROVIDERS — Before a provider requests that Pacific Blue Cross directly pay the provider for product(s) and/or service(s) provided the provider must have the patient first sign the below authorization. This form shall be signed by each patient before any request for a direct payment is made.**

The form must be kept on file for a minimum of three (3) years from the last date of claim submission on the patient's behalf. If Pacific Blue Cross requests a copy of this document, the provider has 21 business days to provide this signed document to PBC.

## PART 1 — PROVIDER INFORMATION

| Provider name | Pacific Blue Cross Provider number |
|---|---|
| | |

## PART 2 — MEMBER INFORMATION

| Policy number | ID number/Personal Health Number (PHN) | Name of plan, company name or Plan sponsor (if applicable) |
|---|---|---|
| **13139** | | **Ministry of Social Development and Poverty Reduction** |

| First name | Last name | Patient's birthdate (mm-dd-yyyy) |
|---|---|---|
| | | |

| Street address | City | Province | Postal code |
|---|---|---|---|
| | | | |

## PART 3 — PATIENT CONSENT AND DECLARATION

I, the patient, authorize the above named provider (the "Provider") to direct bill Pacific Blue Cross ("PBC") on my behalf for product(s) or service(s) or both provided to me.

I consent to PBC collecting indirectly, using and disclosing my personal information, including claims information and supporting health information (the "Personal Information") for the purposes of assessing my eligibility for and providing benefit coverage ("Benefits") to me in accordance with the contract PBC has with the Province of British Columbia, Ministry of Social Development and Poverty Reduction (the "Province"). I understand that this consent includes consent to the sharing of my Personal Information with the Province for purposes related to my Benefits. I also consent to my Personal Information being collected from or disclosed to other health care providers or insurers for the purposes of assessing my eligibility for Benefits. I further consent to PBC receiving or disclosing my Personal Information from or disclosing it to any person who has prescribed or provided Benefits to me for the purposes of the Province or PBC or both conducting inquiries or investigations to verify claims and to ensure that the Provider (or other health care provider) has not made fraudulent or misleading claims, or claims for services or products to which I may not be entitled.

I will respond in a timely way to any inquiries made by the Province or PBC regarding the Benefits claimed on my behalf. I will immediately notify the Ministry of Social Development and Poverty Reduction at 1 866 866-0800 or PBC at 1 877 PAC-BLUE or the PBC Whistleblower online or phone hotline at 1 800 661-9675 if I become concerned that the Provider has submitted or may attempt to submit claims on my behalf that are suspect.

| Patient's signature (or parent/guardian) | Date (mm-dd-yyyy) |
|---|---|
| **X** | |

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