PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

SOMATROPIN REQUEST FORM

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | Fax: 604 419-2689 | Toll-free fax: 1 844 419-2689 | pac.bluecross.ca

PLEASE DO NOT STAPLE

HOW TO COMPLETE THIS FORM:
PLAN MEMBERS — Please complete RED portions of this form.
PHYSICIANS — Please complete BLACK portions of this form.

Don't forget to sign *Part 8 — Member Consent and Declaration* before you submit your claim.

The patient is responsible for any fees charged by the physician for completion of this form. These fees are not eligible for reimbursement under your Pacific Blue Cross Extended Health Care plan.

Completion of this form does NOT imply approval for this drug. Coverage is based on the provisions of your Extended Health Care plan and Pacific Blue Cross qualification criteria.

PART 1 — PLAN MEMBER TO COMPLETE

Plan member's name	Patient's name (if different than Plan member's name)			
Patient's birthdate (mm-dd-yyyy)	**Patient's weight**	**Patient's height**	**Policy number**	**ID number**
Street address	**City**	**Province**	**Postal code**	**Daytime phone number (10 digits)**

PART 2 — PHYSICIAN TO COMPLETE

Physician's name	College ID	Phone number (10 digits)	Fax number (10 digits)
Street address	**City**	**Province**	**Postal code**

Physician's area of specialty: ☐ Endocrinologist ☐ Other: _____

I certify the medical information provided is accurate and current:

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

PART 3 — DRUG REQUESTED

Drug requested	Dosage

Patient is ≤ 20 years of age — Please select one of the following:
☐ Growth Hormone Deficiency*
☐ Turner syndrome
☐ Other: _____
*Include copy of BC PharmaCare special authority

Patient is > 20 years of age — Please select one of the following:
☐ Growth Hormone Deficiency (adult or childhood onset)
☐ Other: _____

PART 6 — ADDITIONAL INFORMATION

_____

_____

_____

PART 7 — MEMBER CONSENT AND DECLARATION

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

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 and pay claims.

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.

If there is overpayment, I authorize its recovery from any amount payable to me under my benefit plan(s).

I have read and understand this Member 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.

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

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

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