



## FASTER PAYMENTS WITH ONLINE CLAIMS\*

Are you claiming expenses for:

- Prescription drugs
- Acupuncture
- Physiotherapy
- Naturopathy
- Massage therapy
- Psychology
- Chiropractic services
- Podiatry
- Orthodontic treatments
- Vision care

You can submit these claims online and know instantly if your claim is approved.

Just sign into CARESnet® and click on *Submit a claim* in the *Claims* tab.

\*Online claims are available to individual plan customers and group plan members whose plan sponsors/employers have opted for this service as part of their benefits plan.



# HEALTH CLAIM FORM

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | [www.pac.bluecross.ca](http://www.pac.bluecross.ca)

**i** Use this form to submit a claim for all medical expenses and services. **Please enclose all supporting documentation, original receipts and complete all parts of this form to avoid delays in processing your claim.** See page 2 for important information about preparing your claim.

## PART 1 — MEMBER INFORMATION

Policy number 7900		ID number	Name of plan, company name or Plan sponsor (if applicable)		
First name		Last name		Employment status <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retiree <input type="checkbox"/> Student	
Street address		City	Province	Postal code	New address? <input type="checkbox"/> Yes

## PART 2 — 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 <input type="checkbox"/> Pacific Blue Cross <input type="checkbox"/> Other insurer: _____			Coverage start date (mm-dd-yyyy)
Member's policy number	Member's ID number	Plan member <input type="checkbox"/> Same as above <input type="checkbox"/> Spouse	Cancellation date if applicable (mm-dd-yyyy)
Spouse's first name if spouse's plan		Spouse's last name if spouse's plan	Employment status of spouse <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Retiree <input type="checkbox"/> Student

## PART 3 — INFORMATION ABOUT YOUR CLAIM

Please provide the first name and birthdate of all eligible dependents with a claim. For each dependent, add up all receipts and provide the total amount of their expenses.

If any expenses are the result of a medical emergency outside your province, visit CARESnet® to download an *Emergency Out-of-Province Claim Form*.

FIRST NAME	BIRTHDATE	TOTAL EXPENSES
	(mm-dd-yyyy)	\$
	(mm-dd-yyyy)	\$
	(mm-dd-yyyy)	\$
	(mm-dd-yyyy)	\$
<b>GRAND TOTAL</b>		\$

**i** Remember to enclose all supporting documentation and original receipts. You can mail your claim to us or drop it off at our Burnaby office.

<p>1. Are the expenses you're claiming:</p> <ul style="list-style-type: none"> <li>The result of a workplace injury? (i.e., WorkSafeBC) <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>The result of a motor vehicle or other accident? <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>Are you seeking damages from a 3rd party? <input type="checkbox"/> Auto <input type="checkbox"/> WorkSafeBC <input type="checkbox"/> Other: _____</li> </ul> <p>(If yes to any of the above, please complete an <i>Accident or Injury Reimbursement Agreement Form</i> available on CARESnet.)</p>	<p>2. Have any of your expenses been paid by another insurance company? (If yes, include photocopies of your receipts and the claim statement provided by the other insurance company.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Apply any unpaid balance(s) to your Health Spending Account? (If applicable, see page 2 for more information.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
---	--

## PART 4 — MEMBER CONSENT AND DECLARATION

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

I understand that the personal information provided on this claim, as well as any other personal information currently held by Pacific Blue Cross about me and my eligible dependents, will be used to determine eligibility for this benefit, assess and pay claims. I hereby acknowledge and agree that the personal information may be exchanged between Pacific Blue Cross and a health care professional, practitioner, institution or health benefits provider, government and regulatory authorities or insurer when needed for the purposes stated above or where reasonably necessary for the purposes of my enrolment or coverage under this group plan, or where required or permitted by law. I consent to the disclosure of my personal information by Pacific Blue Cross to my employer or plan sponsor when required or permitted by law or pursuant to its contractual obligations under my benefit plan. I understand that the personal information will be kept confidential and secure. I understand that I may revoke this consent at any time and acknowledge that should I do so, this claim may not be considered. I understand why the personal information is needed and I am aware of the benefits and risks of consenting or refusing to consent to disclosure. I have read and understand this Member Consent and Declaration. If there is overpayment, I authorize its recovery from any amount payable to me under my benefit plan(s).

If I am making a claim under my Health Spending Account (where applicable), I acknowledge that the person(s) for whom I am making a claim are eligible and I accept full responsibility to ensure all expenses submitted for payment from my Health Spending Account are allowable medical expenses as defined under the Canadian Income Tax Act. I understand I am responsible for payment of any taxes that arise from reimbursement of these expenses.

Member's signature <b>X</b>	Date (mm-dd-yyyy)
--------------------------------	-------------------

## TIPS FOR PREPARING YOUR CLAIM

1. Your policy and identification numbers are on your Pacific Blue Cross ID card.
2. All claims must be submitted with original, paid-in-full receipts which show:
  - Claimant's first and last name
  - Description of item(s) purchased or service(s) rendered
  - Date of each purchase or service
  - Amount charged for each purchase or service
  - Name, address and phone number of supplier or provider
  - Provider registration number (if applicable)
3. Please keep photocopies of your receipts. Pacific Blue Cross does not return original receipts.
4. Place your receipts loose and flat in the envelope — no staples, paperclips or tape.
5. Submit only one of each official receipt. Do not include any cashier or Interac receipts.
6. Visit CARESnet® to view benefits covered by your plan/your claiming deadline or refer to your benefits website at [www.gov.bc.ca/myhr](http://www.gov.bc.ca/myhr).
7. Don't forget to sign *Part 4 — Member Consent and Declaration* before you submit your claim.

**ⓘ INCOMPLETE FORMS MAY DELAY PROCESSING OF YOUR CLAIM.**

## FREEDOM OF INFORMATION AND PROTECTION OF PRIVACY ACT (FOIPPA)

This information is collected by the British Columbia Public Service under s. 26(c) of FOIPPA. Any questions about the collection and the use of this information can be directed to an HR Service Representative at the BC Public Service Agency by submitting a request to AskMyHR at [www.gov.bc.ca/myhr/contact](http://www.gov.bc.ca/myhr/contact), phoning: 1 877 277-0772 or writing to: Manager, Contact Centre Operations, BC Public Service Agency, 810 Blanshard St. Victoria, BC V8W 2H2.



### MAIL YOUR CLAIM

Pacific Blue Cross  
PO Box 7000, Vancouver, BC V6B 4E1



### DROP IT OFF

4250 Canada Way  
Burnaby, BC V5G 4W6



### QUESTIONS?

604 419-2600  
Toll-free: 1 888 275-4672

[www.pac.bluecross.ca](http://www.pac.bluecross.ca)

## SPECIAL INSTRUCTIONS

### COORDINATION OF BENEFITS

Only complete *Part 2 — Other Insurance Coverage* if you or your spouse are covered under another plan. Send your claim to your plan first. When you receive your claim statement, send a copy of that statement plus copies of your receipts to your other plan to claim any unpaid amount.

If you have claims for your children, send those claims first to the plan of the parent whose birthday falls earlier in the year.

Learn more about coordination of benefits at [www.pac.bluecross.ca](http://www.pac.bluecross.ca).

### WORKPLACE, AUTOMOBILE OR OTHER ACCIDENTS

If your claim is a result of a workplace or automobile accident or an incident where third party liability may be involved, please complete and submit an *Accident or Injury Reimbursement Agreement Form* in addition to this *Standard Health Claim Form*. All forms are available on CARESnet.

### ORTHOTICS AND ORTHOPEDIC SHOES

If this benefit is covered by your plan, visit CARESnet to view a list of special claiming criteria and to download an additional form (either the *Custom Foot Orthotics Claiming Checklist* or the *Custom Orthopedic Shoe Claiming Checklist*) which must be submitted with your claim.

### HEALTH SPENDING ACCOUNTS

If this feature is part of your coverage, you can choose to apply any unpaid balance of your claim to your Health Spending Account.

The Canada Revenue Agency can answer your questions about which medical expenses meet the Income Tax Act requirements — call toll-free 1 800 959-8281. A list of eligible expenses can also be found at [www.cra-arc.gc.ca](http://www.cra-arc.gc.ca).

### OUT-OF-PROVINCE EXPENSES

If any of your expenses are due to a medical emergency that happened while you were outside of the province where you live, visit CARESnet to download an *Emergency Out of Province Claim Form*.



Explore CARESnet at

[www.pac.bluecross.ca](http://www.pac.bluecross.ca)

- ✓ Create your account.
- ✓ Submit online claims.
- ✓ Save provider information.
- ✓ Sign up for direct deposit payments.
- ✓ Check your dependent coverage.
- ✓ Track health expenses and limits.
- ✓ Access My Good Health®, an online healthy lifestyle resource exclusive to members of Pacific Blue Cross.
- ✓ Send a copy of your ID card to your mobile device.