



Mailing Address
PO Box 7000
Vancouver, BC V6B 4E1

Street Address
4250 Canada Way
Burnaby, BC

Fax (604) 419-2990
Toll Free 1-888-275-4672

Sales
(604) 419-2100

Extended Health
(604) 419-2600

Dental
(604) 419-2300

Individual & Travel Plans
(604) 419-2200

Short Term Disability
(604) 419-8080

Long Term Disability & Life Claims
(604) 419-8040

Dear Member:

When claiming out-of-province medical expenses, the claim must first be submitted to the Medical Services Plan of BC (MSP). Once payment has been made, Pacific Blue Cross will review the balance of your claim for reimbursement under your Travel Contract.

To avoid any delay or confusion, Pacific Blue Cross will forward your claim to MSP on your behalf and will obtain copies of all necessary information on file until confirmation of payment by MSP is received.

To enable us to file a claim for you with MSP, please return the completed MSP claim form and the Schedule A to us as soon as possible as the claiming deadline for MSP is 90 days from the date of service.

In order for us to process your claim, we require the following information:

- A copy of all medical receipts. (Receipts in a foreign language must be translated into English before being submitted.)
- Details of the nature of illness.
- Details of the circumstances which necessitated medical treatment.
- Any other insurance companies involved? Please provide name(s) and policy number(s).
- Do you have Extended Health benefits? Please provide policy number(s).

Thank you for your cooperation. If you have any questions, please do not hesitate to contact our office at (604)419-2600 or Toll Free at 1-888-275-4672.

Yours truly,

Travel Claims Department

SCHEDULE "A"

Assignment of payment due to insured person or beneficiary under the Medical Protection Act or Hospital Insurance Act.

BETWEEN: _____ of the first part, hereinafter referred to as the Assignor
(Enter the patient's name)

AND Pacific Blue Cross of the second part, hereinafter referred to as the Assignee

AND Her Majesty The Queen in the hereinafter referred to as the Minister
Right of the Province of
British Columbia as represented
by the Minister of Health

The Assignor is a person eligible for insured services or benefits or both under the Province of British Columbia's **Medicare Protection Act** or **Hospital Insurance Act** or both, and as such may receive payment for the above services from the Minister.

The Assignor is under a covenant or obligation under a contract with the Assignee to remit to the Assignee all such payments received for medical services from the Minister.

In consideration of the said obligation to the Assignee the Assignor hereby assigns unto the Assignee all sums of money that shall be owing to the Assignor by the Minister for the above noted contract. The Minister is hereby authorized to pay all such sums directly to the Assignee at the address aforesaid, or at any address the Assignee may from time to time designate, with payment of any such sum to be sufficient discharge to the Minister of and from any indebtedness in that amount to the Assignor, his heirs, executors, or administrators.

DATED this _____ day of _____ 20_____

ASSIGNOR: _____ **WITNESS:** _____
(Patient's signature. If the patient is 18 years or younger, a parent or legal guardian's signature is required.) See below *notation. (Signature of someone 19 years or older, other than the Assignor.)

OCCUPATION: _____

ASSIGNMENT EFFECTIVE FROM: _____ **TO:** _____
(Travel Dates)

* THE ASSIGNOR MUST ALSO BE THE ONE WHO SIGNS THE MEDICAL SERVICES PLAN (M. S. P.'S) OUT OF COUNTRY CLAIM FORM.

PLEASE ENSURE ALL SECTIONS OF THIS SCHEDULE A AND M.S.P. OUT OF COUNTRY CLAIM FORM ARE COMPLETED IN FULL AND RETURNED TO OUR OFFICE AS SOON AS POSSIBLE.

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- Please read instructions on reverse before submitting this form. Ensure you have completed all sections.
- Enclose all original receipts. Keep a copy of the receipts for your records.
- For help completing this form, please call us at 604 419-2600 or 1 888 275-4672.

MEMBER INFORMATION

Plan Member's last name	Plan Member's first name	
Plan Member's address	Plan #/Certificate #	ID # (if applicable)
	Postal code	Daytime phone number ()

CLAIMANTS INFORMATION

1	Name of claimant	Birth date (yy/mm/dd)	Personal Health Number (from your Care Card)
2	Name of claimant	Birth date (yy/mm/dd)	Personal Health Number (from your Care Card)

Does the claimant have any other coverage which may consider these charges? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you or the claimant(s) have a "Gold Credit Card" or any credit cards which may provide travel insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Expiry Date:	
Travel insurance name:	ID/policy #	Bank:	ID/Card #/policy #
Extended Health carrier:	ID/policy #	Trust Company:	ID/Card #/policy #
Other coverage:	ID/policy #	Credit Union:	ID/Card #/policy #

Have you claimed or notified any of the above carriers? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "yes", please indicate the date you notified them (yy/mm/dd)	If "no", please do not claim with them
Country where expenses incurred:		
Date of departure from your province of residence (yy/mm/dd)		Date of return to your province of residence (yy/mm/dd)
Reason(s) for absence from your province of residence: <input type="checkbox"/> Vacation <input type="checkbox"/> Student <input type="checkbox"/> Sabbatical leave <input type="checkbox"/> Moved <input type="checkbox"/> Obtain medical treatment <input type="checkbox"/> Other (please specify)		
Are injuries the result of a motor vehicle accident? <input type="checkbox"/> Yes <input type="checkbox"/> No		Is there a person or entity who is liable for your injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are you taking legal action against a person or entity? <input type="checkbox"/> Yes <input type="checkbox"/> No		If "yes", call the Pacific Blue Cross at 604 419-2600 for claiming instructions.

PLAN MEMBER'S STATEMENT AND CLAIMANT'S AUTHORIZATION FOR RELEASE OF INFORMATION

I certify that the information given on this form is true, correct, and complete to the best of my knowledge. I authorize Pacific Blue Cross to obtain/provide information from/to the provincial medical plan, any doctor, hospital, clinic, person, institution, or other carriers that may have a responsibility in this claim. I also authorize Out of Country Claims, Medical Services Plan, to provide/obtain information to/from the travel insurance or extended health care company that I have named. This is my application for benefits under the Medicare Protection Act and the Hospital Insurance Act.

Assignment of Payment: I authorize Pacific Blue Cross to make payments directly to providers or suppliers for outstanding charges, which are payable benefits under this claim. For payments made on my behalf, I authorize any other carriers to assign eligible benefits to Pacific Blue Cross.

Pacific Blue Cross does not return receipts. Please save our "Explanation of Benefits" for income tax purposes. If you also have coverage with another insurance company, make photocopies of all receipts before sending the originals to Pacific Blue Cross.

X _____
 Plan Member's signature Date

X _____
 Parent's signature or parent/guardian if claimant is a minor Date

How to claim out of province emergency medical expenses

- You may claim, under your Pacific Blue Cross plan, charges in excess of the payment made by your **provincial medical plan** (this includes doctors' services, laboratory procedures, hospitalization, radiology and other eligible expenses). In BC, the **provincial medical plan** is **Medical Services Plan of BC (MSP)**. **Pacific Blue Cross will forward your claim to MSP on your behalf.**
- Complete this form in full (front and back).
- Complete Schedule "A" and BC Ministry of Health OOC claim form in full. Please note that the person who is 19 and over and incurred the expense(s) must sign the form.
- Be sure to include the following with your claim: the original itemized/summarized bills and the original receipts showing the bills have been paid in full, **OR** the outstanding itemized/summarized bills so Pacific Blue Cross may consider payment directly to medical provider(s) or supplier(s).
- Keep copies of bills or receipts for your records.
- Prior to submitting, all bills or receipts must be translated to English/French.
- MSP's claiming deadline is 90 days from the date of service. Forms and any supporting documents relating to your claim must be returned to our office as soon as possible in order to meet the MSP deadline.

1	Name of doctor, hospital, clinic or other expense	Date of service or purchase (mm/dd/yy)	Amount billed (in foreign currency)	For PBC use	For PBC use	Amount paid by provincial medical plan	For PBC use Balance
	Was treatment due to an emergency? <input type="checkbox"/> Yes <input type="checkbox"/> No	Details of illness or injury				Have you paid the account? <input type="checkbox"/> Yes <input type="checkbox"/> No	

2	Name of doctor, hospital, clinic or other expense	Date of service or purchase (mm/dd/yy)	Amount billed (in foreign currency)	For PBC use	For PBC use	Amount paid by provincial medical plan	For PBC use Balance
	Was treatment due to an emergency? <input type="checkbox"/> Yes <input type="checkbox"/> No	Details of illness or injury				Have you paid the account? <input type="checkbox"/> Yes <input type="checkbox"/> No	

3	Name of doctor, hospital, clinic or other expense	Date of service or purchase (mm/dd/yy)	Amount billed (in foreign currency)	For PBC use	For PBC use	Amount paid by provincial medical plan	For PBC use Balance
	Was treatment due to an emergency? <input type="checkbox"/> Yes <input type="checkbox"/> No	Details of illness or injury				Have you paid the account? <input type="checkbox"/> Yes <input type="checkbox"/> No	

4	Name of doctor, hospital, clinic or other expense	Date of service or purchase (mm/dd/yy)	Amount billed (in foreign currency)	For PBC use	For PBC use	Amount paid by provincial medical plan	For PBC use Balance
	Was treatment due to an emergency? <input type="checkbox"/> Yes <input type="checkbox"/> No	Details of illness or injury				Have you paid the account? <input type="checkbox"/> Yes <input type="checkbox"/> No	

5	Name of doctor, hospital, clinic or other expense	Date of service or purchase (mm/dd/yy)	Amount billed (in foreign currency)	For PBC use	For PBC use	Amount paid by provincial medical plan	For PBC use Balance
	Was treatment due to an emergency? <input type="checkbox"/> Yes <input type="checkbox"/> No	Details of illness or injury				Have you paid the account? <input type="checkbox"/> Yes <input type="checkbox"/> No	

6	Name of doctor, hospital, clinic or other expense	Date of service or purchase (mm/dd/yy)	Amount billed (in foreign currency)	For PBC use	For PBC use	Amount paid by provincial medical plan	For PBC use Balance
	Was treatment due to an emergency? <input type="checkbox"/> Yes <input type="checkbox"/> No	Details of illness or injury				Have you paid the account? <input type="checkbox"/> Yes <input type="checkbox"/> No	

Were you treated by a physician for the above illness/injury prior to your departure? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If "yes", please specify the condition(s)	
Name of your family doctor	Phone
Family doctor's address	