

DO NOT WRITE IN THIS SPACE

Mailing Address: PO Box 7000, Vancouver BC V6B 4E1  
Street Address: 4250 Canada Way, Burnaby BC

- 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.
- Please refer to your Pacific Blue Cross EHC/HSA card for your group, ID and dependent numbers.
- For help completing this form, or for more information on your EHC/HSA plan, call us at 604 419-2600 or 1-888-275-4672.

**Member Information**

Member's policy number <b>E</b>	HSA policy number <b>E</b>	Member's identity number	Member's provincial health plan number (Care Card)
Member's last name		Member's first name	
Member's address		Member's company name	
City/Province/Postal code		Check this box if this is a new address <input type="checkbox"/>	Daytime phone number (10 digits)

**Other Coverage**

Do you or your dependents have other insurance to cover these benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	My family is (or I am) registered with Fair PharmaCare <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of the other insurance company	Is your claim the result of an accident? If yes, attach details. <input type="checkbox"/> Yes <input type="checkbox"/> No
Policy number	Is this a WorkSafe BC (WCB) case? <input type="checkbox"/> Yes <input type="checkbox"/> No
ID number	Is this an ICBC, or other auto insurance, case? <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of member with other insurance company	Are you seeking damages from a third party? <input type="checkbox"/> Yes <input type="checkbox"/> No
Employment status <input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Retiree	If any of these expenses are due to a medical emergency while you were outside of the province where you live, visit CARESnet® to download an <i>Out of Province Claim</i> form or contact Pacific Blue Cross.
Effective date (yyyy-mm-dd)	
Cancellation date (yyyy-mm-dd)	

*Note: If you are claiming for the balance not paid by the other insurance company, include photocopies of your receipts and their payment statement.*

**Expense Information**

	First name of claimant (list in dependent and date order)	Birthdate (yyyy-mm-dd)	Dependent number	Type of expense or name of medication (e.g. Hospital, Ambulance, or name of clinic)	Date of each purchase or service or hospital admission and discharge dates (yyyy-mm-dd)	Amount paid	Provider of service or prescriber of medication	Nature of illness or injury*	Apply unpaid balance to HSA plan
1									<input type="checkbox"/> Yes <input type="checkbox"/> No
2									<input type="checkbox"/> Yes <input type="checkbox"/> No
3									<input type="checkbox"/> Yes <input type="checkbox"/> No
4									<input type="checkbox"/> Yes <input type="checkbox"/> No
5									<input type="checkbox"/> Yes <input type="checkbox"/> No
6									<input type="checkbox"/> Yes <input type="checkbox"/> No
7									<input type="checkbox"/> Yes <input type="checkbox"/> No
8									<input type="checkbox"/> Yes <input type="checkbox"/> No
9									<input type="checkbox"/> Yes <input type="checkbox"/> No
10									<input type="checkbox"/> Yes <input type="checkbox"/> No
11									<input type="checkbox"/> Yes <input type="checkbox"/> No
12									<input type="checkbox"/> Yes <input type="checkbox"/> No

\*Optional, but may result in refusal or delay of claim if not provided.

**Total claim (optional):**

**Claimant Statement**

*I certify that I and/or my dependents incurred these expenses and that the information given is true, correct and complete to the best of my knowledge.*

*I authorize the release of any information or record requested in respect of this claim to Pacific Blue Cross or its agents. I understand that personal information collected will be used to determine my entitlement to benefits under this plan and may be disclosed when required or) permitted by law and in accordance with the Pacific Blue Cross privacy policy. The Pacific Blue Cross privacy policy is available at [www.pac.bluecross.ca](http://www.pac.bluecross.ca)*

*I also authorize Pacific Blue Cross or its agents access to any relevant information required to adjudicate this claim.*

Signature	Date
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If the claimant is under 18 years of age, the member's signature is required.

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



Secure online access to benefit information for Pacific Blue Cross members.

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

## IMPORTANT CLAIMING INFORMATION

Incomplete claims may cause delays in processing.

1. Complete all areas on the front of this claim form.
2. Refer to your PBC ID card for your Policy and ID numbers.
3. Keep copies of your receipts and documents for your records.
4. All claims must be submitted with itemized statements and original, paid-in-full receipts, and must include:
  - Claimant's first and last name
  - Description of item purchased or service rendered
  - Date of each purchase or service
  - Amount charged for each purchase or service
  - Name, address and telephone number of supplier or provider
5. Claims must be received in our office before the claiming deadline.
6. An Explanation of Benefits (EOB) statement indicating how the claim was assessed will be sent to the member or posted in CARESnet®. Eligible claims will be paid by cheque, attached to the EOB statement, or by direct deposit to your bank account. The EOB statement can be used for income tax purposes or to claim through other coverage. No other statements will be issued. Register for direct deposit, and to receive and view your EOB statements online, by visiting CARESnet®.
7. Refer to CARESnet® for a list of benefits and conditions of eligibility, or refer to your plan booklet. If you do not have a plan booklet, contact your plan administrator.

### Other Health Benefit Plan Coverage

Photocopies of receipts are acceptable if one the following situations applies:

1. If you are claiming expenses for your spouse and your spouse is covered under another health benefit plan, you must submit the claim to your spouse's plan first.
2. If both you and your spouse have health benefit coverage, your children must claim under the plan of the parent with the earliest birthday (month and day) in the calendar year. *(For example: If your birthday is May 1 and your spouse's is June 5, your children will claim under your plan first).*
3. If you have submitted your original receipt to your other insurance company, please provide the following:
  - Photocopies of all invoices and paid-in-full receipts
  - The original statement from the other insurance company showing payment or denial of your claim.



*Spend time doing the things  
you really want to do.*

We've made it easy to access your benefit and claim information online, so you can get back to doing the other things that matter to you.

- Secure 24-hour access to your benefit and claim information
- View a summary of your EHC or dental plan
- See Health Spending Account\* balances
- Track the status of a current claim
- Inquire about your claim history
- Download claim forms
- Enrol for direct deposit and online Explanation of Benefits statements **NEW!**

\* Available if you have a Health Spending Account as part of your benefit plan

**CARESNET**®

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