PACIFIC BLUE CROSS™

DO NOT WRITE IN THIS SPACE

Extended Health Care Standard Claim Form

Mailing Address
PO Box 7000
Vancouver BC
V6B 4E1

Street Address
4250 Canada Way
Burnaby BC

Member Information

Member's ID number	Policy number	Member's company name	
	E053749	Pebt: Conseil Scolaire Francophone - Sd# 93	
Member's last name	Member's first name	Employment status ☐ Full time ☐ Part time ☐ Retiree	Daytime phone number (10 digits)
Member's address/city/province/postal code			Check this box if this is a new address ☐

Other Coverage

Do you or your dependents have other insurance to cover these benefits? ☐ Yes ☐ No

Name of the other insurance company	
Policy number	ID number
Name of member with other insurance company	Employment status
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.

Is your claim the result of an accident? If yes, attach details. ☐ Yes ☐ No

Is this a WorkSafe BC (WCB) case? ☐ Yes ☐ No

Is this an ICBC, or other auto insurance, case? ☐ Yes ☐ No

Are you seeking damages from a third party? ☐ Yes ☐ No

☑ Check boxes below next to claims that are related to accidental or occupational injuries.

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 Out of Province Claim *form or contact Pacific Blue Cross.*

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*	☑ See above
1									☐
2									☐
3									☐
4									☐
5									☐
6									☐
7									☐
8									☐
9									☐
10									☐
11									☐
12									☐

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

Total claim (optional): 0

Member Consent & Declaration

I certify that the information contained in this and other documents supporting this claim is complete and true to the best of my knowledge. I certify that all expenses claimed under my EHC plan are medically necessary.

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 a purpose stated above.

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.

Signature	Date (yyyy/mm/dd)

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

0332.001 10-60-020 08/10 CUPE 1816

IMPORTANT CLAIMING INFORMATION

Incomplete Extended Health claims may cause delays in processing.

1. Read these instructions before submitting this form.
2. Ensure you have completed all sections.
3. Refer to your Pacific Blue Cross (PBC) ID card for your Policy, ID and dependent numbers.
4. Make photocopies of all receipts before sending the originals to Pacific Blue Cross. Save your Explanation of Benefits statements for income tax purposes.
5. All claims must be submited 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
6. Claims must be received in our office before the claiming deadline.
7. 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®.
8. 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.
9. For help completing this form or for more information on your EHC plan, call us at 604 419-2600 or 1 888 275-4672 or visit CARESnet® at www.pac.bluecross.ca

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.

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