PACIFIC BLUE CROSS™

BC Life

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

PACIFIC BLUE CROSS™ BC Life®

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
And	Pacific Blue Cross	of the second part, hereinafter referred to as the Assignee
And	Her Majesty The Queen in the Right of the Province of British Columbia as represented by the Minister of Health	hereinafter referred to as the Minister

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 indebtness in that amount to the Assignor, his heirs, executors, or administrators.

Dated this _____day of_____ 20 _____

Assignor_____ Witness _____

(signature) (signature)

Occupation _____

Assignment effective from _____to _____

(travel dates)

PACIFIC BLUE CROSS™

Emergency Out of Province Claim Form

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.
- 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

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

Does the claimant have any other coverage which may consider these charges? ☐ Yes ☐ No		Do you or the claimant(s) have a "Gold Credit Card" or any credit cards which may provide travel insurance? ☐ Yes ☐ 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? ☐ Yes ☐ 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: ☐ Vacation ☐ Student ☐ Sabbatical leave ☐ Moved ☐ Obtain medical treatment ☐ Other (please specify)		
Are injuries the result of a motor vehicle accident? ☐ Yes ☐ No	Is there a person or entity who is liable for your injuries? ☐ Yes ☐ No	
Are you taking legal action against a person or entity? ☐ Yes ☐ 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

Secure online access to benefit information for Pacific Blue Cross members: **www.pac.bluecross.ca**

CARESNET®

How to claim out of province emergency medical expenses

1. 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.**
2. Complete this form in full (front and back).
3. 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.
4. 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).
5. Keep copies of bills or receipts for your records.
6. Prior to submitting, all bills or receipts must be translated to English/French.
7. 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.

	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
1							
	Was treatment due to an emergency? ☐ Yes ☐ No	Details of illness or injury				Have you paid the account? ☐ Yes ☐ No	
2							
	Was treatment due to an emergency? ☐ Yes ☐ No	Details of illness or injury				Have you paid the account? ☐ Yes ☐ No	
3							
	Was treatment due to an emergency? ☐ Yes ☐ No	Details of illness or injury				Have you paid the account? ☐ Yes ☐ No	
4							
	Was treatment due to an emergency? ☐ Yes ☐ No	Details of illness or injury				Have you paid the account? ☐ Yes ☐ No	
5							
	Was treatment due to an emergency? ☐ Yes ☐ No	Details of illness or injury				Have you paid the account? ☐ Yes ☐ No	
6							
	Was treatment due to an emergency? ☐ Yes ☐ No	Details of illness or injury				Have you paid the account? ☐ Yes ☐ No	

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

0184—10-60-064 04/06 CUPE 1816

BRITISH COLUMBIA **Ministry of Health Services**

OUT-OF-COUNTRY CLAIM FORM

Return to: Pacific Blue Cross
PO Box 7000
Vancouve, BC V6B 4E1

IMPORTANT ➢ ***Completion of this claim form is essential***

- ➢ *Claims **must** be received **within 90 days** of the date of service*
- ➢ *Attach **all original receipts or bills** to this form. Include **itemized statement***
- ➢ *Retain copies of bills or receipts for your records*
- ➢ *Receipts not in English **must be translated** before being submitted*
- ➢ *Form **must be signed** by patient or legal guardian*
- ➢ *Refer to Section D on the back before completing this form*

Personal information on this form is collected under the authority of the *Medicare Protection Act.* The information will be used to determine residency in BC and determine eligibility for provincial health care benefits. If you have any questions about the collection of this information, contact an MSP client representative at the address or telephone number shown at the end of the form. Personal information is protected from unauthorized use and disclosure in accordance with the *Freedom of Information and Protection of Privacy Act* and may be disclosed only as provided by that Act.

SECTION A - PATIENT INFORMATION

PERSONAL HEALTH NUMBER (ON CARECARD) | DATE OF BIRTH *Month* *Year* | SEX ❒ MALE ❒ FEMALE

NAME OF PATIENT (FAMILY NAME) | GIVEN NAMES | TELEPHONE NUMBER Home: Work:

POSTAL ADDRESS
Number and Street or Box No. | City / Town | Province | Postal Code

RESIDENTIAL ADDRESS OF PATIENT (*If different from above*)
Number and Street | City / Town | Province | Postal Code

HAS PATIENT LIVED AT ABOVE ADDRESS 6 MONTHS PRECEDING DEPARTURE FROM B.C.? ❒ YES ❒ NO *If No, provide residential address(es) where patient was living*

Number and Street	City / Town	Province	Postal Code	From *Month* *Year*	To *Month* *Year*

NAME AND ADDRESS OF PRESENT OR LAST EMPLOYER IN BRITISH COLUMBIA OF ❒ PATIENT OR ❒ HEAD OF FAMILY *(Check appropriate box)*
Name | Address

NAME OF A PERSON *(not a relative)* WHO CAN CONFIRM PATIENT'S RESIDENCE IN BRITISH COLUMBIA
Name *(in full)* | Address *(include Postal Code)*

REASON FOR ABSENCE FROM BRITISH COLUMBIA
❒ VACATION ❒ OBTAIN MEDICAL CARE ❒ BUSINESS TRIP
❒ MOVED ❒ STUDENT ❒ OTHER *(specify):*

	Month	*Day*	*Year*
DATE OF DEPARTURE FROM B.C.			
DATE OF RETURN TO B.C.			

DO YOU HAVE EXTENDED HEALTH BENEFITS INSURANCE OR TRAVEL INSURANCE? ❒ YES ❒ NO | NAME OF COMPANY | POLICY NUMBER

ARE YOU OR ANY DEPENDENTS COVERED BY HEALTH INSURANCE IN ANOTHER COUNTRY? ❒ NO ❒ YES *If YES, attach statement of payment of claims.*

RELEASE OF INFORMATION

The information on this form is collected under the authority of the Medicare Protection Act (R.S.B.C.1992, c. 76) and the Hospital Insurance Act (R.S.B.C.1979, c.180)

I _____ hereby authorize Out-of-Country Claims, Medical Services Plan, to obtain information
Name of patient
necessary for the processing of my claim from the Hospital and/or Doctor who provided care or in the event of an appeal on this case to provide the appeal board with the appropriate information in order for an informed decision to be made.

I also authorize Out-of-Country Claims, Medical Services Plan, to provide/obtain information to/from the above named travel insurance or extended health benefits company.

In addition, my signature below is my Application for Benefits under the Hospital Insurance Act of British Columbia (for in-patient hospital charges).

I certify that I am the person entitled to receive benefits and that all statements made by me are true and correct .

X _____ _____
Patient's Signature *Date*

SECTION B - TO CLAIM FOR DOCTOR'S FEE COMPLETE THIS SECTION

THE REASON FOR SEEKING MEDICAL ATTENTION (DIAGNOSIS)

TREATMENT / PROCEDURE	**DURATION OF ANAESTHETIC** ________ Hrs. ________ Min. *or* From: To:
LABORATORY TESTS	CHARGE $
SPECIFY EACH AREA X-RAYED	CHARGE $

DOCTOR'S NAME AND SPECIALTY	DATE *Month*	*Day*	*Year*	TYPE OF VISIT	TIME OF VISIT	CHARGE	COUNTRY AND CURRENCY
				❒ Office ❒ Home ❒ Hospital	❒ 8 a.m. - 6 p.m. ❒ 6 p.m. - 11p.m. ❒ 11p.m. - 8 a.m.		

WERE YOU REFERRED BY ANOTHER DOCTOR? If so, please provide name and address

HAVE YOU PAID THE ACCOUNT? ❒ YES ❒ NO

DOCTOR'S NAME AND SPECIALTY	DATE *Month*	*Day*	*Year*	TYPE OF VISIT	TIME OF VISIT	CHARGE	COUNTRY AND CURRENCY
				❒ Office ❒ Home ❒ Hospital	❒ 8 a.m. - 6 p.m. ❒ 6 p.m. - 11p.m. ❒ 11p.m. - 8 a.m.		

WERE YOU REFERRED BY ANOTHER DOCTOR? If so, please provide name and address

HAVE YOU PAID THE ACCOUNT? ❒ YES ❒ NO

DOCTOR'S NAME AND SPECIALTY	DATE *Month*	*Day*	*Year*	TYPE OF VISIT	TIME OF VISIT	CHARGE	COUNTRY AND CURRENCY
				❒ Office ❒ Home ❒ Hospital	❒ 8 a.m. - 6 p.m. ❒ 6 p.m. - 11p.m. ❒ 11p.m. - 8 a.m.		

WERE YOU REFERRED BY ANOTHER DOCTOR? If so, please provide name and address

HAVE YOU PAID THE ACCOUNT? ❒ YES ❒ NO

DOCTOR'S NAME AND SPECIALTY	DATE *Month*	*Day*	*Year*	TYPE OF VISIT	TIME OF VISIT	CHARGE	COUNTRY AND CURRENCY
				❒ Office ❒ Home ❒ Hospital	❒ 8 a.m. - 6 p.m. ❒ 6 p.m. - 11p.m. ❒ 11p.m. - 8 a.m.		

WERE YOU REFERRED BY ANOTHER DOCTOR? If so, please provide name and address

HAVE YOU PAID THE ACCOUNT? ❒ YES ❒ NO

DOCTOR'S NAME AND SPECIALTY	DATE *Month*	*Day*	*Year*	TYPE OF VISIT	TIME OF VISIT	CHARGE	COUNTRY AND CURRENCY
				❒ Office ❒ Home ❒ Hospital	❒ 8 a.m. - 6 p.m. ❒ 6 p.m. - 11p.m. ❒ 11p.m. - 8 a.m.		

WERE YOU REFERRED BY ANOTHER DOCTOR? If so, please provide name and address

HAVE YOU PAID THE ACCOUNT? ❒ YES ❒ NO

DOCTOR'S NAME AND SPECIALTY	DATE *Month*	*Day*	*Year*	TYPE OF VISIT	TIME OF VISIT	CHARGE	COUNTRY AND CURRENCY
				❒ Office ❒ Home ❒ Hospital	❒ 8 a.m. - 6 p.m. ❒ 6 p.m. - 11p.m. ❒ 11p.m. - 8 a.m.		

WERE YOU REFERRED BY ANOTHER DOCTOR? If so, please provide name and address

HAVE YOU PAID THE ACCOUNT? ❒ YES ❒ NO

SECTION C - TO CLAIM FOR IN-PATIENT HOSPITAL CHARGES COMPLETE THIS SECTION

- *In-patient hospital charges include registered bed patient, dialysis, and surgical day care.*
- *Entitlement for hospital benefits is dependent upon residency and it is therefore essential that Sections A and C be completed in the fullest possible detail.*
- ***A separate application is required for each admission to hospital for which a claim is made.***
- *The information requested in this form refers specifically to the person hospitalized. In the case of a dependent child it is necessary to supply particulars of the residence of the head of family.*
- *If the condition of the person requiring admission to hospital does not permit him/her to apply on his/her own behalf, or if he/she is an underage dependent, this form should be completed by a member of the family or some other person having knowledge of the facts.*

NAME OF HOSPITAL	HOSPITAL ADMISSION NUMBER
POSTAL ADDRESS OF HOSPITAL	DATE OF ADMISSION *Month* *Day* *Year*
	DATE OF DISCHARGE *Month* *Day* *Year*

ADMITTING DIAGNOSIS (NATURE OF ILLNESS) AND TREATMENT PROVIDED DURING HOSPITALIZATION

HAVE YOU PAID THE HOSPITAL ACCOUNT? ❒ NO ❒ YES, *Enclose proof of payment*

WAS THIS ADMISSION TO HOSPITAL THE RESULT OF AN ACCIDENTAL INJURY? ❒ NO ❒ YES, *Complete the following*

DESCRIBE HOW ACCIDENT TOOK PLACE *(Give names of other persons involved and details of their insurance, if any)*

DATE OF ACCIDENT	ACCIDENT LOCATION	WHO DO YOU THINK WAS RESPONSIBLE FOR THE ACCIDENT?

WHERE HOSPITALIZATION IS THE RESULT OF A **MOTOR VEHICLE ACCIDENT,** COMPLETE THE FOLLOWING

IF **TWO-CAR** COLLISION GIVE:

A. FULL NAME AND ADDRESS OF **OTHER** DRIVER

NAME

ADDRESS

B. NAME AND ADDRESS OF OTHER DRIVER'S AUTOMOBILE INSURANCE COMPANY & POLICY NUMBER

NAME

ADDRESS

POLICY NUMBER

IF YOU WERE A **PEDESTRIAN** OR **CYCLIST** STRUCK BY AN AUTOMOBILE GIVE:

A. FULL NAME AND ADDRESS OF DRIVER

NAME

ADDRESS

B. NAME AND ADDRESS OF OTHER DRIVER'S AUTOMOBILE INSURANCE COMPANY & POLICY NUMBER

NAME

ADDRESS

POLICY NUMBER

IF YOU WERE IN AN AUTOMOBILE SHOW WHETHER YOU WERE ❒ DRIVER OR ❒ PASSENGER, IF PASSENGER GIVE:

A. FULL NAME AND ADDRESS OF DRIVER

NAME

ADDRESS

B. NAME AND ADDRESS OF OTHER DRIVER'S AUTOMOBILE INSURANCE COMPANY & POLICY NUMBER

NAME

ADDRESS

POLICY NUMBER

ICBC CLAIM NUMBER *(if applicable)*	SIGNATURE
	X

Where a beneficiary receives in-patient hospital services for accidental injuries received as a result of the wrongful act or omission of some other person, the amount of benefits is reduced by the amount of any settlement or award received by the beneficiary in respect of the cost of such hospital services from the person alleged to have been responsible for causing the injuries.

SECTION D - GENERAL INFORMATION

The Medical Services Plan insures out of province medical services required on an emergency basis during a temporary absence and claims must be submitted **within 90 days** from the date of service.

The plan pays for medically required treatment by a qualified **Doctor (M.D.)** up to B.C. rates, any difference in fees is the beneficiary's responsibility.

In-patient hospital benefits are provided to eligible British Columbia residents who are taken ill or are accidentally injured outside British Columbia.

Payment can be made directly to the doctor/hospital. The beneficiary will be reimbursed if the account has been paid.
In instances where there is a small amount payable or the facility/doctor does not accept Canadian currency, payment may be made to the patient. The facility/doctor will be advised of such payments and the patient is responsible for payment of the account.

Please allow 12-16 weeks for processing.

ELECTIVE SERVICES If the beneficiary wishes to seek medical attention outside the province, ***prior authorization*** must first be obtained from the Medical Services Plan through the Medical Advisor before seeking service and before the service is rendered.

ADDITIONAL BENEFITS NOT COVERED OUTSIDE THE PROVINCE

- Chiropractic
- Naturopathic Physicians
- Optometry
- Special Nursing
- Physiotherapy
- Massage Therapy
- Podiatry
- Victoria Order of Nursing

THE FOLLOWING ARE NOT INSURED BENEFITS

- Certified Physician Assistant
- Registered Nurse Practitioner
- Ambulance charges
- Prosthesis and Appliances
- Frames, Eyeglasses and Contact Lenses
- Care in Health Spas and similar facilities
- Nurse anaesthetist
- Drugs
- Transportation, Accommodation expenses
- Supplies
- Use of the Emergency Room
- Medical care at the request of a third party
  (i.e. Insurance, School Admission Examinations, Driver's License, and treatment for which the Workers' Compensation Board, Department of Veteran's Affairs, or other Government agency is responsible)

DENTAL AND ORAL SURGICAL PROCEDURES

Dental and Oral surgical procedures are included as benefits ***only*** when medically required to be performed in a hospital where the insured person is admitted as an in-patient or as a patient under Day Care Surgical services.

FOR FURTHER INFORMATION WRITE:

Victoria Office

Ministry of Health Services
Medical Services Plan
Out-of-Country Claims
PO Box 9480 Stn Prov Govt
Victoria BC V8W 9E7

Phone: (250) 952-2654
Fax: (250) 952-2964

BEFORE MAILING:

Please ensure that all areas of the claim form are complete

Attach all receipts or bills to this form. Include itemized statements

Ensure that you have signed all appropriate areas