

BCPSEA EHC claim form

BRITISH COLUMBIA
PUBLIC SCHOOL EMPLOYERS'
ASSOCIATION
Extended Health Care 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.
- Please refer to your Pacific Blue Cross EHC card for your group, ID and dependent numbers.
- For help completing this form, or for more information on your EHC plan, call us at 604-419-2600 or 1-888-275-4672.

MEMBER INFORMATION

| | | | | |
|--|--------------------------|---------------------|-------------------------|----------------------------------|
| Company name | | Member's last name | Member's address | |
| Group number E | Member's identity number | Member's first name | Postal code | Daytime phone number () |
| Member's provincial health plan number (Care Card) | | | Member's E-mail address | |

EXPENSE INFORMATION

| Name of dependent claiming (list in dependent and date order) | Birth date mm/dd/yy | Dependent number | Type of expense or name of medication (Example: hospital, ambulance, or name of clinic) | Date of each purchase or service or hospital admission and discharge dates mm/dd/yy | Amount paid | Provider/prescriber of service | Nature of illness or injury |
|--|------------------------|---------------------|---|---|----------------|-----------------------------------|--------------------------------|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

My family is (or, I am) registered with Fair PharmaCare Yes No

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

Is this a Workers' Compensation (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

Are any of these expenses due to a medical emergency while you were outside of the province where you live? If yes, please contact Pacific Blue Cross for an *Out of Province* claim form.

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

| | |
|---|----------------------------|
| Name of the other insurance company | |
| Group number | ID number |
| Name of member with other insurance company | |
| Effective date mm/dd/yy | Cancellation date mm/dd/yy |

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

▣▣▣▣ Total Claim:

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 a photocopy of all receipts before sending the originals to Pacific Blue Cross.

I certify that I and/or my dependents incurred these expenses. All information is correct.

I consent to Pacific Blue Cross using this personal information to adjudicate my claim and disclosing this information when required or permitted by law or pursuant to its contractual obligations under my benefit plan.

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

X _____
Member's signature Date

IMPORTANT CLAIMING INFORMATION

Please provide all information requested on both pages of this claim form. Pacific Blue Cross is unable to process incomplete claims.

- 1) Submit all claims with itemized statements and original paid receipts, which indicate:
 - patient's name
 - type of purchase or service
 - date of each purchase or service
 - amount charged for each purchase or service

Pacific Blue Cross is unable to accept photocopies unless you have submitted the original receipts to your other insurance company. If so, attach copies of your receipts and a copy of their payment statement.

- 2) List all expenses in dependent and date order.
- 3) Pacific Blue Cross will only consider paying claims that exceed your deductible. See your Pacific Blue Cross EHC card or brochure for information about your plan deductible.
- 4) All claims must be received in the office of Pacific Blue Cross no later than December 31st of the year following the date of purchase or service (unless otherwise agreed upon by your Employer). Late submissions will not be accepted.
- 5) Submit your EHC claims regularly (Pacific Blue Cross suggests about every three months). *Do not hold your claims until the claiming deadline.*

Your EHC plan may include a deductible and a reimbursement percentage (example: \$25.00 deductible, balance paid at 80%). Check your plan brochure for details.

All BC residents covered by the Medical Services Plan of BC are eligible for Fair PharmaCare benefits. If you have not already done so, please register with Fair PharmaCare in order to maximize your financial eligibility. Expenses paid in part by Pacific Blue Cross may be eligible with Fair PharmaCare and should be submitted to Fair PharmaCare first for their consideration. (Examples:

prosthetic appliances, ostomy supplies.) Submit to Fair PharmaCare for payment by March 31st of the year following the service or purchase. When you purchase prescription drugs, your pharmacist submits claims to Fair PharmaCare on your behalf.

To claim for the benefits listed below, see the specific instructions.

Check your plan brochure for a list of eligible benefits and the conditions when these benefits are eligible.

PRESCRIBED DRUGS

- official PharmaCare receipt

SERVICES (physiotherapist, chiropractor, podiatrist, naturopath, massage practitioner)

- type of service
- date of each treatment
- amount charged for each treatment
- therapist's name and phone number

HOSPITAL ACCOMMODATION

- type of room (semi-private, private)
- admission and discharge dates
- daily charge
- a description of any additional charges

AMBULANCE

- reason for taking the ambulance
- date of service
- places ambulance taken from and to
- amount charged

OUT OF PROVINCE MEDICAL EXPENSES

Please contact your plan administrator to obtain the following forms:

- MSP Out-of-Country claim form
- Emergency Out-of-Province Expense claim form
- *Schedule A*

Complete all necessary forms and submit to Pacific Blue Cross promptly in order that we may submit your claim to MSP within their 90 day deadline.

HEARING AIDS

Please check your plan brochure for any age restrictions.

REGISTERED NURSES

Along with your receipts, Pacific Blue Cross requires a letter from the attending doctor, indicating the diagnosis, that he or she ordered the nurse's services, and the necessity for the services.

ORTHOPEDIC SHOES

Along with your receipts, Pacific Blue Cross requires a letter from the orthopedic surgeon, doctor or podiatrist, indicating the diagnosis, the necessity for prescribing the shoes, and the type of shoes prescribed.

DENTAL ACCIDENTS

Along with your receipts, Pacific Blue Cross requires from the dentist a detailed list of services performed. We also require the exact date of the accident, the circumstances of the accident, and information on any other dental coverage. Include all relevant X-rays.

THIRD PARTY LIABILITY

Your EHC plan does not pay for any benefits if a third party is liable by law. For claims due to an accident, indicate if there is possible third party liability. If yes, please contact Pacific Blue Cross for further information, as you must complete third party forms.

VISION CARE

Not all EHC plans cover vision care benefits. Check your plan brochure. Submit itemized receipts, that show the purchase date and the patient's name.



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