PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

# IWA FOREST INDUSTRY LTD PLAN MEDICAL TRAVEL ALLOWANCE REFERRAL & CLAIM FORM

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | Fax: 604 419-2149 | enrollment@pac.bluecross.ca

Use this form to submit a claim for all medical expenses and services. **Please enclose all supporting documentation, original receipts and complete all parts of this form to avoid delays in processing your claim.** See page 2 for important information about preparing your claim.

## PART 1 — MEMBER INFORMATION

| | | | |
|---|---|---|---|
| Member's ID number | Policy number | Member's company name | |
| Member's last name | Member's first name | Member's email address | Daytime phone number (10 digits) |
| Member's street address | City / Province | Postal code | New address? ☐ Yes |
| Patient's last name | Patient's first name | Dependent number | Patient's birth date (mm-dd-yyyy) |

## PART 2 — CLAIM FOR TRAVEL EXPENSES

| | | | | |
|---|---|---|---|---|
| 1. Private automobile | From (location of residence) | To (location of specialist) | Total Km (round trip) | Amount claimed (km x $.30) |
| 2. Air/BC Ferries/taxi fares | From (location of residence) | To (location of specialist) | Total Km (round trip) | Amount claimed (km x $.30) |
| 3. | From (location of residence) | To (location of specialist) | Total Km (round trip) | Amount claimed (km x $.30) |
| 4. | From (location of residence) | To (location of specialist) | Total Km (round trip) | Amount claimed (km x $.30) |

## PART 3 — CLAIM FOR ACCOMMODATION EXPENSES

| | | | |
|---|---|---|---|
| Name of hotel/motel | Location | Number of days | Amount claimed |
| Name of hotel/motel | Location | Number of days | Amount claimed |
| Name of hotel/motel | Location | Number of days | Amount claimed |
| Name of hotel/motel | Location | Number of days | Amount claimed |
| | | **TOTAL AMOUNT CLAIMED** | |

## PART 4 — MEMBER CONSENT AND DECLARATION

**IMPORTANT: This section must be signed before submitting your claim.**

I understand that expenses payable under the Workers Compensation (WCB) Act, Medical Services Plan (MSP) of British Columbia, Insurance Corporation of BC (ICBC) or other sources, are not eligible for reimbursement and I certify that the reimbursement I am seeking is related to the medical appointment referred to in this form and that all the information is correct.
I certify that the medical travel specified is more than 500 km (round trip) from my place of residence.

| | |
|---|---|
| Member's signature<br>**X** | Date (mm-dd-yyyy) |

## PART 5 — REFERRAL TO A MEDICAL SPECIALIST (to be completed by the referring physician)

| | | |
|---|---|---|
| Patient's name | Referred to (name of medical specialist) | Location |
| Reason for referral | | |
| Referral date (mm-dd-yyyy) from | Appointment date (mm-dd-yyyy) to | If there are more than two months between the referral date and appointment date, explain |
| Attendant/escort is required ☐ Yes ☐ No | If yes, reasons attendant is required | |

## PART 6 — MEMBER CONSENT AND DECLARATION

**IMPORTANT: This section must be signed before submitting your claim.**

I confirm that the patient has attended the appointment as referred.

| | |
|---|---|
| Medical Specialist's signature<br>**X** | Date (mm-dd-yyyy) |

Submit your claim within 90 days of the date eligible expenses were incurred.

# IMPORTANT CLAIMING INFORMATION

Provide all the information requested on the front of this claim form. Incomplete forms cannot be processed and will be returned.

Refer to your Pacific Blue Cross ID card for your policy, ID and dependent numbers.

Submit original paid receipts (photocopies are not acceptable), which indicate:

- patient's name
- type of purchase or service
- date of each purchase or service
- amount charged for each purchase or service

Keep a copy of the receipts for your records, as PBC does not return receipts.

Referral to a Medical Specialist section:

- Part 1 must be completed by the local physician who is referring the patient
- Part 2 must be completed by the specialist to whom the patient has been referred.

Submit your claim within 90 days of the date eligible expenses were incurred.

Mail your claim to:
Pacific Blue Cross
PO Box 7000
Vancouver BC V6B 4E1

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

PACIFIC BLUE CROSS®

**MAIL YOUR CLAIM**
Pacific Blue Cross
PO Box 7000, Vancouver, BC V6B 4E1

**DROP IT OFF**
4250 Canada Way
Burnaby, BC V5G 4W6

**QUESTIONS?**
604 419-2600
Toll-free: 1 888 275-4672

**www.pac.bluecross.ca**


**Explore CARESnet at**
**www.pac.bluecross.ca**

- Create your account.
- Submit online claims.
- Save provider information.
- Sign up for direct deposit payments.
- Check your dependent coverage.
- Track health expenses and limits.
- Access My Good Health®, an online healthy lifestyle resource exclusive to members of Pacific Blue Cross.
- Send a copy of your ID card to your mobile device.