PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

PAY PROVIDER AUTHORIZATION

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | pac.bluecross.ca

PROVIDERS — Before a provider requests that Pacific Blue Cross directly pay the provider for product(s) and/or service(s) provided, or to be provided to the patient, the provider must have the patient first sign the below authorization. This form shall be signed by each patient before any request for a direct payment is made.

The form must be kept on file for a minimum of three (3) years from the last date of claim submission on the patient's behalf.
If Pacific Blue Cross requests a copy of this document, the provider has 21 business days to surrender this document.

PART 1 — PROVIDER INFORMATION

Provider name	Pacific Blue Cross Provider number

PART 2 — MEMBER INFORMATION

Policy number	ID number/Status number	Name of plan, company name or Plan sponsor (if applicable)

First name	Last name

PART 3 — PATIENT INFORMATION

Patient's first name	Patient's last name	Patient's birthdate (mm-dd-yyyy)	

Street address	City	Province	Postal code

Relationship to Plan member: ☐ Self ☐ Spouse ☐ Child

PART 4 — PATIENT CONSENT AND DECLARATION

I, the patient, authorize the above named provider to direct bill Pacific Blue Cross (PBC) on my behalf for product(s) and/or service(s) provided to me or my dependent(s).

I consent to the collection, use and disclosure of my personal information and that of my dependent(s) for the purposes of PBC conducting inquiries or investigations to verify claims, to ensure that my provider is submitting claims in accordance with PBC's requirements, and that the claims submitted on my behalf are accurate including the actual product(s) or service(s) delivered, the benefit(s) the service(s) is billed to, who received treatment, and the quantity of product(s) or service(s) delivered.

I further agree that I am to use my best efforts to verify all claims submitted by my provider on my behalf by monitoring my claim statements received via the online Member Profile or mailed to me; and will notify PBC immediately if I discover any claiming activity that is unknown or suspect.

If PBC finds that any false or misleading claims have been submitted by my provider on my behalf, PBC may take action to correct any inaccurate claiming activity. If it is found that I colluded in allowing the provider to submit false or misleading claims on my behalf PBC may recover such amounts from me, suspend my benefits or privileges, and/or exercise the right of set-off.

Patient's signature (or parent/guardian) **X**	Date (mm-dd-yyyy)

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