PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

ASSIGNMENT OF PAYMENT FORM PROVIDER

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | Tel: 604 419-2000 | Toll-free: 1 877 PAC-BLUE | pac.bluecross.ca

Assignment of payment will only be considered for amounts greater than $1,000.
When this form is completed and received by Pacific Blue Cross, it allows us to pay a person or party other than the plan holder. All original receipts and invoices must be attached. Please do not resubmit this form with every claim.

PART 1 — MEMBER INFORMATION

Policy number	ID number	Name of plan, company name or Plan sponsor (if applicable)	
First name	Last name	Employment status ☐ Full-time ☐ Part-time ☐ Retiree ☐ Student	Daytime phone number (10 digits)
Street address	City	Province	Postal code / New address? ☐ Yes

PART 2 — OTHER INSURANCE COVERAGE (Please sign below)

Complete this section if you or your spouse are covered under another plan.

Other insurance coverage ☐ Pacific Blue Cross ☐ Other insurer: _____			Coverage start date (mm-dd-yyyy)
Member's policy number	Member's ID number	Plan member ☐ Same as above ☐ Spouse	Cancellation date if applicable (mm-dd-yyyy)
Spouse's first name if spouse's plan	Spouse's last name if spouse's plan	Employment status of spouse ☐ Full-time ☐ Part-time ☐ Retiree ☐ Student	Spouse's birthdate (mm-dd-yyyy)

PART 3 — INFORMATION ABOUT YOUR EXPENSE

In reference to the attached claim, I hereby request and authorize Pacific Blue Cross to pay direct to the following supplier the full amount of benefits payable for expenses incurred by:

DATE OF EXPENSE	PATIENT	PAYEE
(mm-dd-yyyy)	First and last name	Name
(mm-dd-yyyy)	First and last name	Address
(mm-dd-yyyy)	First and last name	Daytime phone number (10 digits)

PART 4 — MEMBER CONSENT AND DECLARATION

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

In making this assignment, I understand and agree that any balance **not** covered by the Extended Health Benefits Plan(s) listed above is/are my/our responsibility. Monies paid by Pacific Blue Cross on behalf of a member to a medical supplier must be returned to Pacific Blue Cross if the item/service cost is refunded.

I understand the personal information collected on this form will be used to determine eligibility for this benefit and pay claims. I acknowledge and agree that the personal information may be exchanged between Pacific Blue Cross and supplier, health care professional, practitioner, institution or health benefits provider, government and regulatory authorities, or insurer when needed for this purpose.

Member's signature (Part 1) X	Date (mm-dd-yyyy)
Member's signature (If completing Part 2) X	Date (mm-dd-yyyy)
Witness signature X	Date (mm-dd-yyyy)

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