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1.0 Introduction

Thank you for being a part of Pacific Blue Cross’s network of Providers. Together we can help improve the health and well-being of British Columbians. As part of our commitment to service, Pacific Blue Cross publishes this reference guide to assist Providers with submitting claims on behalf of Members.

It is important that you read this guide and become familiar with its contents. Every time a claim is submitted to Pacific Blue Cross, it indicates your understanding of and agreement with the terms, conditions, and guidelines set out in this guide.

Icons

Icons have been added throughout this document to highlight content. They are:

New Icon Information has been added/updated.

Important Icon Information that is crucial to benefits or submission requirements.

There is a Glossary in the Appendix that outlines terms specific to this Reference Guide.

2.0 About Pacific Blue Cross

Pacific Blue Cross, a not-for-profit company, has been British Columbia’s leading benefits Provider for over 75 years. Our comprehensive understanding of changing health care needs fuels our commitment to service.

Pacific Blue Cross is an independent, not-for-profit organization. Because we’re not-for-profit, our resources are used to serve stakeholders, not stockholders. This means any financial surplus we generate is completely reinvested into the business for the current and future benefit of our Members.

Together with BC Life, our subsidiary, we provide health, dental, life, disability, and travel coverage to nearly 1.5 million British Columbians through employee group plans and through individual plans for those who do not have coverage with their employer. Pacific Blue Cross and BC Life continue to respond to customers’ needs in plan design, administration and technology.

Contact Us

Local (Within Metro Vancouver): 604-419-2000
Toll-Free: 1-877-PAC-BLUE
Website: providernet.ca
3.0 Blue Cross Plans

This guide has been structured to assist you in submitting claims for Pacific Blue Cross Members. Before you submit claims for our Members, we want to inform you about the different Blue Cross Plans. Some plans are controlled by Pacific Blue Cross while National Blue Cross plans may be controlled by any one of the Canadian Blue Cross carriers. It is important to understand these differences, when applicable.

3.1 Plans

Pacific Blue Cross administers many different types of plans that can be classified into three broad categories:

1. **Employer/Association-Sponsored Plans**: These are group plans sponsored by employers, unions, associations, or trusts, that provide benefit coverage for their Members.

2. **Individual Health Plans**: These are plans purchased by individuals in British Columbia and the Yukon. Individuals may be self-employed, without employer benefits, choose to supplement their employer’s benefits, or retired.

3. **Government-Funded Plans**: These are plans for individuals in British Columbia and the Yukon that are funded by a government program. Examples of government-funded plans are:

   - **First Nations Health Authority (FNHA)** provides coverage for its clients. As of September 16, 2019, Pacific Blue Cross has administered medical supply and equipment, vision, hearing, dental and some pharmacy claims on their behalf.
   - **The Ministry of Children and Family Development (MCFD)** provides coverage for Children in Care. Pacific Blue Cross administers vision and dental claims on their behalf.
   - **The Ministry of Social Development and Poverty Reduction (MSDPR)** provides coverage for British Columbians in need. Pacific Blue Cross administers vision, hearing, and dental claims on their behalf.

Please refer to the First Nations Health Authority and Ministry of Social Development and Poverty Reduction sections in this guide for further information.
4.0 Identifying Blue Cross Members

4.1 Overview
There are different types of identification that you can use to verify that a customer is covered by Blue Cross. Members are to present their identification cards prior to receiving the product or service from the Provider.

4.2 Pacific Blue Cross Identification Cards
A Member’s Pacific Blue Cross card is a single-sided paper card that is the size of a bank card.

Pacific Blue Cross identification cards first indicate the Member’s policy number, which is a unique number assigned to each participating company or group (Plan Sponsor). The ID number shown next on the card is unique to the Member. The same policy and ID numbers should be used for each member of the family.

In some instances, a third party administers employee benefits on behalf of Pacific Blue Cross and may issue their own wallet-sized card (e.g., student plans). In these cases, the Pacific Blue Cross logo does not appear on the card; however, Pacific Blue Cross is listed as the carrier (insurer). These cards should also be accepted as valid cards.

4.3 Status Cards
A client’s Status Number can be found on their Certificate of Indian Status (Status Card). A Status Number is used by First Nations Health Authority (FNHA) Members as identification.

FNHA Policy Number: 40000

For further information on about FNHA client identification and eligibility see the FNHA Section.

4.4 Personal Health Number (PHN)
A client’s Personal Health Number (PHN) can be found on their British Columbia Driver’s License or British Columbia Services Card. A PHN is used by Ministry of Social Development and Poverty Reduction (MSDPR) and Ministry of Children and Family Development (MCFD) clients as identification. MSDPR and MCFD clients must reside in British Columbia.

MCFD Policy Number: 77030
MSDPR Policy Number: 13139

For further information on about MSDPR client identification and eligibility see the MSDPR Section.
4.5 National Blue Cross Identification Cards
A Member’s National Blue Cross card is double-sided and plastic, similar to bank cards but without raised lettering. The design of these cards is consistent across all regions. Customers have the option of an English or French card, based on the Member’s preference.

Blue Cross Contact Numbers
Local (British Columbia): 604-419-2381
Toll Free: 1-888-873-9200

Card information includes: Member’s name, ID number, and policy number.
5.0 Becoming a Pacific Blue Cross Provider

5.1 Overview
Becoming a Pacific Blue Cross Provider allows you to submit claims to Pacific Blue Cross on behalf of your eligible patients. This is not only convenient for your patients, but also increases your business’ efficiency.

5.2 Duly Registered
The dental practitioner verifies that they are duly registered under the laws of their province or territory to practice. The dental practitioner agrees to advise Pacific Blue Cross as soon as reasonably possible if they are no longer registered to practice with their regulatory college or has limits or conditions placed on their registration. Pacific Blue Cross will not pay for services rendered by a dental practitioner who is not registered to practice, or provides services outside of their scope of practice, or outside of limits and conditions on their practice.

Denturists: Prior to billing partial denture services, you must apply and receive approval by the College of Denturists of BC and then successfully complete the required examination.

Independent Hygienists: Pacific Blue Cross will only register and reimburse independent hygienists working outside of the traditional dental office setting.

Pacific Blue Cross reserves the right to determine who is eligible as a Provider.

5.3 How to Register as a Dental Provider
Visit provdernet.ca for the application form for new registrations.

Follow the prompts to begin the registration process. It’s important that all information be accurate and complete so that there are no delays.

Before submitting your application, ensure that you have the following:

- The 9-digit unique number (UIN) assigned by the CDA/DAC/CDHA
- The 4-digit office number assigned by the CDA/DAC/CDHA
- The office address

There are other resources for Providers available on our website, including:

- FAQs
- Client-Specific Fee Supplements
- Registration Checklist
Pacific Blue Cross will review your application.
- After you have registered you will receive an activation email. Click on the activation code in the email. You will be prompted to enter in your 4-digit Provider ID. This is either your CDAnet®/DACnet™ office number or a 4-digit number Pacific Blue Cross has assigned to your office. (e.g. 1234, X1234)
- If your application is denied, you will be emailed the reason and may re-apply (if applicable).

5.4 Helpful PROVIDERnet® Terminology
As you are going through the application process, there may be some terms that are not familiar to you or terms that are used in a very specific context. To assist you in the application process, we have outlined these terms here.

**Primary Administrator:** The Primary Administrator has access to add/edit banking information and view pre-authorizations and claim statements. The Primary Administrator can also set up another Primary Administrator if they choose to grant someone else that access.

**Example:** Dental practitioner, office manager

**Provider:** This refers to the physical office location.

**Example:** Dental on Main Street

**Standard Administrator:** This is an optional secondary account to the Primary Administrator account. They have access to eligibility, claim statements and pre-authorization but do not have access to view or change banking information.

**Example:** Front desk staff, office reception

**Key Points**
- Primary Administrator and Standard Administrator email addresses **must be unique.** This is because each email address is linked to an access profile.
- Web accounts that are not in use for six months are automatically deactivated for security; you will need to call us at 604-419-2000 or toll-free at 1-877-PAC-BLUE to reactivate your account.
6.0 About PROVIDERnet

6.1 Overview
All approved Pacific Blue Cross Providers will be given access to PROVIDERnet.

PROVIDERnet is a comprehensive website that is designed to give Pacific Blue Cross Providers the ability to set up direct deposit for their store and view electronic statements. It also includes access to current and past communications and resources. You can sign up and keep your information up-to-date simply by visiting providernet.ca.

6.2 Technical Requirements
Using PROVIDERnet is simple, easy and secure.

Visit pac.bluecross.ca/browsers for detailed information on web browser requirements and tips on connection and screen resolution.

6.3 Activate Your PROVIDERnet Account
Once your application has been approved, you will receive an email that includes your Provider ID.

---

This is the beginning of a beautiful partnership.
Hello Jane Public,

We are pleased to inform you that your registration for a Provider ID Number from Pacific Blue Cross has been approved.

The following is your Provider and Corporate information:

Provider ID: 0001
Provider Name: Dental Clinic Name
Provider Address: 123 Any St
Corporate Contact Name: Jane Public

What happens next?

Separate emails with an unique activation code will be sent separately to the individuals listed above so each can complete their online account activation for PROVIDERnet.

The Provider ID above will be required to activate these user accounts.
To activate your web account, click on the activation code in your email.

Enter in your Provider ID and the Account Activation Code you received in your email.

Create your password and challenge questions.

Read the User Agreement and Privacy Policy, then click the I accept the User Agreement and Privacy Policy checkbox.
You have successfully created your account and will be sent a confirmation email.

6.4 Administer User Accounts
PROVIDERnet has two types of user accounts for dental offices, as outlined in Section 5.4 of this guide.

Select Account then Administer User Accounts.

Next, select Create New User Account.
Enter First Name, Last Name and Email of the person you want assigned to that role.

Select Role either Primary Administrator or Standard.

Key Points

- Do not use an email address where multiple people have access (i.e. clinic email, general inbox) for the Primary Administrator Email. Only individuals with permission to change banking information and view other highly confidential information should have access to the email account provided for Primary Administrator.
- The Primary Administrator is responsible to set up and maintain web accounts for others in your dental office and assign roles.
- When staff leave the clinic it’s important to terminate their web account.
- When you sign up for direct deposit you will only receive electronic statements.

Remember to update your records with us when you leave a clinic.
6.5 Direct Deposit
Dental practitioners can sign up for direct deposit whether they work at a single office location or multiple office locations.

Note: To ensure privacy and security, Pacific Blue Cross staff cannot set up direct deposit information. This is a self-serve function only.

Navigate to the Account tab menu option and select Payments > Direct Deposit.

Select Update Direct Deposit Info and follow the prompts to add your business’ banking information.

Read the Terms and Conditions before you click Save.

Dental practitioners working in more than one location can submit bank account information that is:
1) Specific to each office location or
2) The same across each office location

Separate EFT payments will be provided for dental practitioners for each office location worked at.

Note: Only the Primary Administrator role can view, add, edit or delete bank account information.

6.6 Keeping Your Information Up to Date
It is your responsibility to keep your records with Pacific Blue Cross up to date. Please ensure that you notify Pacific Blue Cross in the event of any changes to ownership within 7 business days before the change is to occur.

To update your information, visit providernet.ca and click Make UPDATES to your account for the following:
- Closing a Provider Office
- Change of Address
- Change of Office Name
6.7 Forgot Your Password?
If you have forgotten your password to log in to PROVIDERnet, go to the login page and select Forgot your password?

Enter your Provider ID Number and email address, then click Continue.

You will be prompted to answer one of your challenge questions. After successfully answering your challenge question, a temporary password link will be sent to the email address associated with the account.

Now you can log in to your account and update your password.

Note: This temporary password is only active for 24 hours.

6.8 Check Eligibility
PROVIDERnet features a Plan Benefit and Eligibility Lookup tool that gives you access to dental coverage information for Pacific Blue Cross members, Ministry of Social Development and Poverty Reduction (MSDPR) clients and First Nations Health Authority (FNHA) clients.

Click on the Eligibility tab and click Eligibility Lookup.
Enter the Policy and ID number for Pacific Blue Cross members, Personal Health Number (PHN) for MSDPR clients, or Status Number for FNHA clients and click Search. Verify the member/client information and select the Individual. Enter a specific Fee Number or click AutoFill for a plan breakdown. Click View for the results of the member’s plan.

Note: Confirmation of eligibility is not a guarantee of payment or coverage. A member’s status can change at any time. Information for National Blue Cross members is not available on PROVIDERnet.
6.9 Check Predeterminations
Predeterminations can also be viewed on PROVIDERnet that are issued to your office.

Click on the Eligibility tab and click Pre-authorizations.

Enter the Policy and ID number for Pacific Blue Cross members, Personal Health Number (PHN) for MSDPR clients, or Status Number for FNHA clients and click Search.

Verify the member’s information and select the Individual.

Use the Date Range fields to narrow or expand your search. Click Apply.

The results are listed for the individual selected and can be displayed in a PDF format.

Note: Any treatments sent to Pacific Blue Cross for pre-determination are to determine member eligibility only. Providers must be prepared to submit supporting documentation (i.e. clinical notes, x-rays, photographs, etc.) related to the treatment being pre-determined upon request.
7.0 Claiming Procedures

7.1 Overview
Prior to submitting claims to Pacific Blue Cross, there are several key claiming guidelines that you should know.

The Provider will submit claims in accordance with the criteria in this Pacific Blue Cross Reference Guide, alongside the criteria of the applicable Fee Guides/Schedules/Supplements for specific plans that Pacific Blue Cross administers or may participate in (e.g. FNHA, MSDPR).

Pacific Blue Cross reimburses claims at the applicable plan percentages indicated in the Member’s plan design.

7.2 Provider ID Numbers
All submissions, including paper, must show both of the following ID numbers of the practitioner performing the services:
1. The complete 9-digit unique ID number (UIN) or Pacific Blue Cross assigned ID number. Be sure to include all 9-digits, even when the number begins with zeros.
2. The 4-digit CDA/DAC office number or Pacific Blue Cross assigned office number. Practitioners providing services at multiple locations must be registered at each individual location.

7.3 Fee Item Numbers and Tooth Numbers
Bill the Fee Item Number of the actual procedure performed.
The dental practitioners must bill the actual procedures performed. Do not substitute an alternative fee item number. For some Pacific Blue Cross dental care plans, a lower cost alternative may be allowed for certain dental services based on certain criteria. In these cases, Pacific Blue Cross will determine the applicable basic rate for payment.

Do not bill more than one item on a claim line (e.g. extractions). Bill each tooth and fee item number on a separate line.

Use the International Tooth Numbering System for all procedures requiring a tooth number.

**Dentists only:** Tooth numbers, surfaces and tooth number areas are needed for all restorative, surgical and some periodontal procedures.

**Denturists only:** Tooth numbers and tooth number areas (e.g. arch) are needed as noted in the Pacific Blue Cross Fee Schedule

In the Pacific Blue Cross Fee Schedule, look for the tooth symbol \( \text{ Tooth symbol } \) which denotes when a tooth number or tooth area (e.g., sextant ID or arch) is required.

If the description of the procedure performed differs from the fee item number, or there are unusual circumstances, write an explanation in the *Additional information* section of the claim form. If more space is required, please enclose a separate note or a second claim form.
Pacific Blue Cross reserves the right to request a predetermination and a second opinion on proposed or performed services. Claims for services submitted without prior approval are reviewed before reimbursement is considered.

7.4 Lab Fees (Dentist/Denturist only)
For each service that requires a lab, itemize the total professional fee and the total lab fee. Do not bill lab fees on a separate line from the service they pertain to as Pacific Blue Cross does not reimburse on partial billings. Lab bills and radiographs are not necessary, unless specifically requested by Pacific Blue Cross or in cases where the lab bill amount exceeds the professional fee. For electronic claims, submit the professional and lab fee amounts separately as indicated in the Pacific Blue Cross Dental Fee Schedule. Do not submit a combined professional and lab fee amount.

Please refer to the MSDPR Dentist/Denturist Fee Schedules to understand how lab fees are to be billed to PBC as many claims should be submitted as one combined billed amount.

7.5 Orthodontics (Dentist only)
Some Pacific Blue Cross dental care plans provide orthodontic coverage either immediately or after a waiting period. It is important to submit an orthodontic treatment plan before treatment begins.

The treatment plan must include:
1. A complete detailed clinical description.
2. Length of treatment indicating monthly or quarterly fees over the length of the estimated active treatment.
4. Breakdown of costs indicating: consultation fee, records fee, initial payment and monthly or quarterly fee.
5. Fee item number 80002 to identify the treatment plan.

Payments made before treatment is performed are not eligible. Pacific Blue Cross provides payment for completed services only.

Treatment is considered in progress when diagnostic services are concluded, impressions for appliances are taken and the down payment is made. The remaining balance can then be claimed as monthly or quarterly payments. Note that if the patient pays the full amount before treatment is complete, or makes a down payment greater than 50% of the total treatment cost, Pacific Blue Cross prorates the eligible expenses throughout the estimated active treatment period. Monthly payments are issued until the patient reaches the maximum dollar limit, completes the treatment or plan coverage cancels, whichever occurs first.

Advise patients to submit claims as outlined in the treatment plan. Patients should not collect receipts over a year or wait until treatment is completed before submitting a claim. Claims received after one year from the date the fees were due are not eligible and the Member cannot collect payment.

Additional charges outside of the treatment plan for items such as missed appointments, late/financing/interest/insurance charges and/or replacement of lost, stolen or broken appliances should be clearly noted on the claim form or receipt. Payment for these additional charges is the responsibility of the patient and they are not eligible benefits.
To assist your patients with submitting claims, please complete dental claim forms indicating the appropriate fee item numbers. Invalid or discontinued fee item numbers will be rejected.

01901  Examination and diagnostic records
80002  Treatment Plan
93331  Initial Fee
93332  Monthly Fee
93333  Quarterly Fee
93334  One Time Appliance
80631  Repairs
89706  Miscellaneous (This fee item number is not to be used for ineligible charges such as: missed appointments, late or financing charges, interest and insurance charges.)

Important: If billing solely for an orthodontic appliance, a completed treatment plan is still required for approval.

7.6 Patient Signatures
A patient signature (parent/guardian for minors) is required on all claim forms in the section that acknowledges services rendered and release of information. [This requirement does not apply to Ministry of Children and Family Development (MCFD) or Ministry of Social Development and Poverty Reduction (MSDPR) claims]. Claims will be returned if there is no patient signature. Do not obtain patient signatures on blank or incomplete claim forms.

Pacific Blue Cross is unable to accept "signature on file” as an alternative for the patient's signature; however, Pacific Blue Cross will accept this in the other employee/plan Member/subscriber sections. Pacific Blue Cross does not require the patient’s signature on adjustments or resubmissions as long as the claim originally submitted was signed or was submitted via CDAnet®/DACnet™. For claims submitted electronically through CDAnet®/DACnet™, dental offices must ensure they have the patient and Member signatures on file as per the CDAnet®/DACnet™ Subscription Agreement.

7.7 Provider Signature on Adjustments/Resubmissions
Resubmissions and adjustment requests do not require an authorized signature if the original claim submitted was signed or the claim was transmitted via CDAnet®/DACnet™. Similarly, we do not require the patient’s signature on adjustments or resubmissions provided the original claim submitted was signed, or the claim was transmitted via CDAnet®/DACnet™.

The original claims must include the authorized signature of the dental office as this confirms that the work was completed and accurately billed. The dental practitioner remains solely responsible for all claims submitted.
8.0 Coordination of Benefits (COB)

8.1 Guidelines
Pacific Blue Cross bases order of submission rules off the Canadian Life and Health Insurance Association (clhia.ca) guidelines. Total reimbursement will never exceed 100% of the eligible amount (excludes non-standard plans who allow for different eligible amounts).

The order of submission for multiple plans is:
1) The plan where the person is covered as a Member.
2) The plan where the person is covered as a dependent spouse.
3) If a person is a Member (cardholder) of two plans, priority goes to:
   i. the plan where the Member is an active full-time employee.
   ii. the plan where the Member is an active part-time employee.
   iii. the plan where the Member is a retiree.
4) Primary coverage for dependent children is determined by:
   i. the plan of the parent with the earlier birth date (MM/DD) in the calendar year.
   ii. the plan of the parent whose first name begins with the earlier letter in the alphabet when the parents have the same birth date.
5) In situations of separation or divorce, where there is single custody, the following order applies:
   i. the plan of the parent with custody of the child.
   ii. the plan of the spouse of the parent with custody of the child.
   iii. the plan of the parent not having custody of the child.
   iv. the plan of the spouse to the parent not having custody of the child.
6) In situations of separation or divorce where there is joint custody, the following order applies:
   i. the plan of the parent with earlier birth date (MM/DD) in the calendar year.
   ii. the plan of the parent with later birth date (MM/DD) in the calendar year.
   iii. the plan of the spouse of the parent with earlier birth date (MM/DD) in the calendar year.
   iv. the plan of the spouse of the parent with later birth date (MM/DD) in the calendar year.

8.2 Coverage with Another Insurance Carrier
For customers whose additional coverage is with another health benefits carrier, continue to submit two claims with the pertinent plan information with each claim to each benefits carrier. The amount paid by the primary plan is always required along with your claim form when submitting a COB claim where Pacific Blue Cross is the secondary plan. Claims submitted without a statement from the primary carrier indicating the amount paid for each line item will be rejected until this documentation is provided.

8.3 Dual Pacific Blue Cross Coverage
For patients with more than one Pacific Blue Cross plan, or whose additional coverage is with a national Blue Cross plan, it is not necessary to submit two claim forms. You may submit only one claim form or predetermination and simply indicate the ‘dual’ coverage information for the second plan in the appropriate area on the form. For electronic claims, when there are two Pacific Blue Cross plans, they will be coordinated automatically.
8.4 Provide all COB Information
To prevent the delay of assessment please provide any pertinent information that will assist Pacific Blue Cross in determining the order of payment. It is a requirement to retain proof of payment (copy of the Explanation of Benefits) when another carrier is involved. This assists with the processing of a claim when deductibles or limitations are reached under the primary plan. If the primary plan is no longer in effect, please contact Pacific Blue Cross to provide the termination date.

8.5 Some Plans May Not Allow COB
The Member should verify eligibility with the plan administrator as some plans do not allow duplicate coverage.

8.6 Some Plans are Always Primary
A plan that does not have a COB provision is always primary and pays before a plan that does have a COB provision.

8.7 Some Plans are Always Secondary
Some plans always pay last. Here is a quick reference for some COB plans:

<table>
<thead>
<tr>
<th>External Insurance</th>
<th>Pacific Blue Cross Insurance</th>
<th>Secondary Payer</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>General Block of Business</td>
<td>FNHA</td>
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<td>✓</td>
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<td>Any client with possible overlapping coverage</td>
</tr>
</tbody>
</table>
9.0 Dental Claim Form

9.1 Overview
Pacific Blue Cross accepts the industry standard dental claim forms (i.e., Canadian Dental Association standard dental claim form, Denturist Association of BC standard dental claim form, the national dental hygiene form for independent hygienists, etc.) or the Pacific Blue Cross dental claim form which you can download from pac.bluecross.ca.

9.2 Claim Form Requirements
Pacific Blue Cross requires the Member’s policy and identification number, the patient’s signature, the patient’s date of birth, relationship to the Member, the patient’s full name and current address. Payment is delayed or denied if incorrect numbers and information are indicated on the claim.

The next page shows an example of the Pacific Blue Cross claim form.

Follow this guide when completing a Pacific Blue Cross dental claim form:

Part 1 – Patient Information
• Enter the patient’s first and last name and complete current address.
• If the procedures require further explanation, enter the information below the patient name and address.

Part 2 – Provider Information
• Enter the complete 9-digit unique number (UIN), 4-digit office number, office address, and practitioner specialty (if applicable)
• An authorized signature from the Provider’s office is required. This confirms that the work was successfully completed and the billing is correct. Unsigned claims are rejected for missing signature.

Part 3 – Plan Member
• Indicate where payment is to be sent by selecting either plan Member (pay patient) or Provider. Without this information the claim cannot be processed for payment and is returned. If payment is going to Provider, have the patient sign in the designated areas on the form.

Part 4 - Claim Information
• Enter the service date. This date must be the final completion date.
• Enter the procedure code. Use one line for each fee item number.
• Enter a short description of the services.
• Indicate the tooth number or tooth area (e.g. sextant ID). If more than one tooth is involved, indicate the additional tooth numbers in the “additional information” box under patient name/address.
• Indicate the surface names (if applicable).
• Enter the professional fee for each line.
• If there is a lab fee, indicate the amount for each line. Grouped billings are NOT acceptable and are returned.
• Enter the total amount billed (professional fee plus lab fee).

Part 5 - Employee/Member
• Enter the policy, ID, employer name, daytime phone number, full name and date of birth for the employee/plan Member.

Part 6 - Patient Information
• Indicate Relationship to plan Member and patient’s date of birth.
• Signature of the patient is required. Unsigned claims are rejected for missing signature.

**Part 7 - Other Coverage**

• When a patient has other dental coverage, this section **must be completed in full**. Failure to do so will result in the claim being returned for clarification.

⚠️ **Note:** *An incorrect or incomplete form will delay payment.*
10.0 Pacific Blue Cross Claim Statements

10.1 Overview
The Pacific Blue Cross Provider Statement lists the following items:

1. Dental practitioner name and address (mailing address)
2. Date – The date the statement was printed.
3. Your Office Number (4-digit)
4. Your UIN Number (9-digit)
5. Page number.
6. Cheque number/Direct Deposit Number – This is the payment number that appears on a physical cheque attached to the statement or on the Electronic Funds Transfer (EFT) statement.

Dental Claim Summary
7. Total claimed amount – The total amount for all Members on the statement.
8. Amount paid by PBC plan – The total amount covered by all Pacific Blue Cross plans.
9. Total payment amount – The total payment amount once co-payments and deductible have been satisfied.

Details
10. Claim ID – A number assigned to each transaction.
11. Service Date – The date shown is the exact date the work was performed.
12. Tooth Number
13. Claimed Procedure – Fee Item Number
14. Claimed Amount – The total cost of the Fee Item Number indicated.
15. Eligible Amount – The amount that is eligible under the plan.
16. Deductible amount – The amount applied to the plan's deductible if applicable.
17. Percent covered – Plan percentages vary based on plan design.
18. Plan Paid Procedure – The Fee Item Number that is eligible under the plan (may alternate).
19. Plan Paid Amount – The balance represents the portion the Member pays out of pocket.
22. ID number – Identifies each Pacific Blue Cross Member.
23. Patient Name.
### Dental Claim Summary

Total claimed amount: $255.00
Amount paid by PBC plan: $255.00
Total payment amount: $255.00

#### Details

<table>
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<tr>
<th>Claim ID</th>
<th>Service Date</th>
<th>Tooth No</th>
<th>Procedure</th>
<th>Amount</th>
<th>Eligible Amount</th>
<th>Deductible Amount</th>
<th>Percent Covered</th>
<th>Plan Paid Procedure</th>
<th>Plan Paid Amount</th>
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<td>政策编号: 1234 ID号: 123456789 患者姓名: Jane Smith</td>
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<td>政策编号: 1234 ID号: 123456789 患者姓名: Joe Smith</td>
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</table>

**PLEASE RETAIN FOR TAX PURPOSES**
11.0 Fraud Prevention

We want to encourage Providers to learn how to recognize and report fraud in order to help stop it.

11.1 Help Prevent Identity Fraud

Prior to accepting coverage and completing a sale for a new customer, check that they have either one piece of PRIMARY ID or two pieces of SECONDARY ID to verify their identity as a Pacific Blue Cross Member.

<table>
<thead>
<tr>
<th>Primary</th>
<th>Secondary</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Driver’s license</td>
<td>• Provincial/Territorial health care plan card</td>
</tr>
<tr>
<td>• Passport</td>
<td>• Birth certificate</td>
</tr>
<tr>
<td>• Provincial/Territorial ID card issued by the Province/Territory</td>
<td>• Canadian citizenship card</td>
</tr>
<tr>
<td>• Police Identity Card issued by RCMP or Municipality</td>
<td>• Landed immigrant status papers</td>
</tr>
<tr>
<td>• Certificate of Indian Status Card</td>
<td>• Naturalization certificate</td>
</tr>
<tr>
<td>• Student ID card</td>
<td>• Marriage certificate</td>
</tr>
<tr>
<td>• Birth Certificate</td>
<td>• Change of Name certificate</td>
</tr>
</tbody>
</table>

11.2 Whistleblower Hotline

Pacific Blue Cross is committed to protecting the integrity of the benefit plans provided to Members. The Whistleblower Hotline is a program that allows Members, Providers and employees to anonymously report fraud and unethical behaviour. Administered by an independent third party on behalf of Blue Cross, all information relating to the report is kept private, confidential and secure, including any caller or Member communication. The Whistleblower Hotline is available at pbc-ethics.com or call 1-800-661-9675. Pacific Blue Cross will investigate all incidents reported.
12.0 Provider Guidelines

12.1 PROVIDERnet

12.1.1 Legal Terms and Conditions
When Providers register for PROVIDERnet, they must accept and comply to the PROVIDERnet Legal Terms and Conditions. They must accept these terms before creating their PROVIDERnet account. These terms are also re-acknowledged each time online banking is updated.

12.2 Payment of Claims
Pacific Blue Cross plans provide coverage for some expenses. Pacific Blue Cross reimburses claims at the applicable contractual plan percentages.

The Provider understands that Pacific Blue Cross contracts may contain deductibles, co-payment amounts, dollar limitations and maximum provisions. Payment of the uninsured portion, including the co-payment, is the customer’s responsibility.

12.2.1 Partial Payment
The Provider certifies that every claim for services submitted to Pacific Blue Cross is a true and accurate account of services rendered, is properly payable, and may be unpaid or partially unpaid by another payer (e.g. provincial government agency or benefit carrier). If there is another payer, the Provider will advise Pacific Blue Cross and will forward a copy of the primary plan’s Explanation of Benefits statement to coordinate payment.

12.2.2 Billing and Co-Payment
Pacific Blue Cross reimburses claims at the applicable plan percentages of the Fee Schedule indicated in the Member’s plan design. The Provider must bill the actual product or service being provided. If a discount is given to the Member, bill the actual discounted amount. If discounting to non-insured patients, the same discounted fee should be extended to insured patients. It is the Provider’s responsibility to collect any co-payment amount from the Member; the co-payment must be collected whether the fee is discounted or not. The co-payment is the Member’s responsibility.

12.2.3 Insured and Non-Insured Charges
The cost of any products or services must not differ between insured and non-insured customers. If discounting to non-insured customers, the same discounted fee should be extended to insured Members.

12.2.4 Claiming Deadline
Submit claims as soon as possible at point of sale. In no event will payment be made on any claim received later than one year from the date of service (excludes non-standard plans with different claiming deadlines).

12.2.5 Items Not Picked Up
If a Member cancels a request for an item or is unable to pick up an item, the Provider may not submit a claim for this item to Pacific Blue Cross for reimbursement.

Note: Some plans publish guidelines to support providers when clients do not pick up an item. Please refer to the FNHA Fee Supplement for further information.

12.2.6 Missed Appointments
If a Member misses or cancels an appointment, Pacific Blue Cross will not pay for the appointment or administrative fees.

Note: Some plans publish guidelines to support providers when clients miss an appointment. Please refer to the FNHA Fee Supplement for further information.
12.2.7 Overpayment/Adjustment
In the event that there is an overpayment, Pacific Blue Cross will adjust the balance owing on a future statement. An overpayment may result from a claim adjustment request from your office or a case where Pacific Blue Cross identified a claim that needed to be adjusted.

An adjustment is a claim that has already been submitted once before. All adjustment requests must indicate "Adjustment" directly on the claim form and the specific reason this request is being made. If information is not provided the claim will not process correctly, resulting in an overpayment, or rejection as a duplicate claim. If your adjustment request involves a claim being reprocessed under MSDPR emergency coverage, a note must be on the claim with this information.

Please continue to notify us of adjustments by mail, on a paper claim or on a copy of your statement. You can also request an adjustment by calling Customer Services at 604-419-2000 or 1-877-PAC-BLUE. Once the error is adjusted, the correction will show on your next statement.

In situations when an overpayment is not recovered from your next payment, Pacific Blue Cross will invoice the office. In this case, please send Pacific Blue Cross a cheque or return our computer-generated cheque. Pacific Blue Cross cannot accept your Provider’s cheque to refund for an overpayment or adjustment while ongoing claims are being processed for your Provider location.

Pacific Blue Cross requests your cooperation to only send cheques if your office receives an invoice indicating an amount is owed to Pacific Blue Cross.

12.2.8 Currency
Pacific Blue Cross will pay all claims in Canadian dollars.

12.3 Date of Service
**All Dental Practitioners:** The date of service indicated on the claim must be the actual date services are rendered for procedures that require only a single office visit. Pacific Blue Cross will not pay for incomplete or unsuccessful services.

**Dentists and denturists:** For procedures which require more than one office visit, the final completion date or the actual insertion date must be used for the date of service. Services and procedures must be completed and considered successful before submitting a claim for payment. For Dentists, this includes: Root canal therapy, crown and bridgework and other major restorations, which must also be billed on the completion date. Temporary procedures are the responsibility of the patient.

To expedite claims processing through automation, date of service should be provided in full MM-DD-YYYY. Please include all leading zeros for Days and Months: correct: 01-13-2019; incorrect: 1-13-19.

12.4 Accidental Dental (Dentists/Denturists Only)
Accidental dental claims are defined as procedures required as a result of a direct external blow to the mouth or face. The accident must have caused immediate damage to the natural teeth or prosthetics and not be the result of an object intentionally or unintentionally placed in the mouth.

Submit a paper claim clearly marked "Accidental Dental," for all accidental dental claims and predeterminations and include the required information. **Do not submit these claims electronically.**
12.5 Specialists (Dentist Only)
If the patient is referred to a certified specialist* and lives in British Columbia, the eligible amount is the Pacific Blue Cross Dental Fee Schedule amount plus 10%.

If the patient lives outside of British Columbia and is referred to a specialist, the eligible amount is the provincial Dental Fee Guide in their province plus 10%.

Some group plan or individual plan contracts do not allow for the 10% specialist fee amount. Have your patient confirm eligibility, check PROVIDERnet®, or submit a predetermination before work is completed.

*Defined by the provincial regulatory college bylaws.

12.6 Relatives
Pacific Blue Cross will not pay for products and services provided to a Member who is a close relative to a Provider, or who lives in the same dwelling as the Provider.

12.7 Confidentiality of Personal Information
Pacific Blue Cross and Providers will collect, use, disclose and retain the personal information of Members in compliance with the applicable provincial or federal privacy legislation in the province or territory where the products or services are provided.

12.8 Indemnity
The Provider shall indemnify and save Pacific Blue Cross and its directors, employees and agents harmless from and against any and all damages, losses, expenses or liabilities (including assessed costs of litigation and assessed legal fees) awarded against or incurred by Pacific Blue Cross to the extent that such damages, losses, expenses or liabilities are brought in connection with items provided by the Provider.

12.9 Intellectual Property
Neither Pacific Blue Cross nor the Provider shall reproduce or use the corporate name or logos owned or licensed by one another in any written material without prior written consent.

12.10 Endorsements
A Provider cannot make claims that their products or services have been endorsed over another Providers’ by Pacific Blue Cross, either in writing or orally.

12.11 Assignment
The Provider cannot assign any of their rights or responsibilities with Pacific Blue Cross without Pacific Blue Cross' written consent.

12.12 Amendment
Pacific Blue Cross reserves the right to amend this reference guide from time to time and Pacific Blue Cross shall post the guide online at providernet.ca.

The Provider acknowledges and agrees it has read this Reference Guide, understands all of the provisions and will comply with the rules and procedures currently in force. The Provider is responsible and agrees to access the current Reference Guide from the Pacific Blue Cross website at providernet.ca. Pacific Blue Cross may amend the Reference Guide annually or as required and will notify the Provider when amended.
12.13 Termination of Pay Direct Privilege

If a Provider location is closing permanently, they must inform Pacific Blue Cross in writing. The Pay-Provider relationship previously established with Pacific Blue Cross will be terminated.

If a Provider fails to comply with any of the items in this reference guide, their status may be reviewed, and Pacific Blue Cross may refuse to accept claims from the Provider.

Pacific Blue Cross reserves the right to refuse claims from a Provider where there is suspicion, or an active investigation of and/or evidence of fraud, misrepresentation or abuse and terminate from the Pacific Blue Cross registry.

Pacific Blue Cross reserves the right to determine which Providers are eligible in its pay direct arrangement and may refuse, suspend, or revoke this privilege if a Provider fails to adhere to the provisions outlined in this guide.

If Pacific Blue Cross removes the pay direct privilege from a Provider, Pacific Blue Cross will not accept claims from the Provider.
13.0 Audit

13.1 Background

Pacific Blue Cross ensures the accuracy and validity of each claim through its claims processing controls as well as employing a comprehensive approach to claims audit.

All claims submitted to Pacific Blue Cross are subject to audit by our Audit, Investigations and Quality Assurance Department. Audits are performed to ensure dental claims, and other eligible benefits and services paid by Pacific Blue Cross are in compliance with the Pacific Blue Cross Fee Schedule, applicable benefits contracts, policies and procedures and any updates to those documents that are communicated from time to time in our bulletins and newsletters.

It is important to note that approval of predetermination or successful adjudication of a claim does not prohibit Pacific Blue Cross from auditing the claim or the dental office that submitted the claim. If during an audit it is found that Pacific Blue Cross successfully adjudicated a claim where the claim was inappropriate or lacked the required records or documentation to support the claim, then Pacific Blue Cross retains the right to recover previously made payment(s).
14.0 **Appendix 1:** First Nations Health Authority (FNHA)

14.1 Introduction

The First Nations Health Authority (FNHA) is the first province-wide health authority of its kind in Canada. The FNHA is the health and wellness partner to over 200 diverse First Nations communities and citizens across BC. In 2013, the FNHA began a new era in BC First Nations health governance and health care delivery by taking responsibility for the programs and services formerly delivered by Health Canada. Since then the FNHA has been working to address service gaps through new partnerships, closer collaboration, health systems innovation, reform and redesign of health programs and services for individuals, families, communities and Nations.

The FNHA is also a champion of culturally safe practices throughout the broader health care system. Taking a leadership role, the FNHA actively works with its health partners to embed cultural safety and humility into health service delivery and improve health outcomes for First Nations people.

The FNHA’s community-based services are largely focused on health promotion and disease prevention and include:

- Primary health care through more than 130 medical health centres and nursing stations;
- Child, youth and maternal health;
- Mental health and wellness;
- Communicable disease control;
- Environmental health and research;
- Health benefits;
- eHealth and telehealth;
- Health and wellness planning; and
- Health infrastructure and human resources.

The FNHA has partnered with Pacific Blue Cross to administer medical supply and equipment, pharmacy, vision, hearing, and dental claims.

14.2 Overview

The sections that follow outline only where there are different procedures for FNHA clients.

Payment is based on the information submitted on the claim, confirmation of client eligibility, and FNHA policy and guidelines.

14.3 Client Identification

As outlined in [Identifying Blue Cross Members](#), FNHA Clients will use their Status Number as found on their Status Card as their identification number for Pacific Blue Cross Benefits. A Status Card contains a 10-digit number, issued by the Government of Canada to Clients registered under the *Indian Act*. The policy number for FNHA Clients is 40000. Status Cards are unique to each individual. The only time that more than one individual will be registered under a status card is when a child under 18 months has not yet been registered; in this case they will be registered under the parent’s status card.

To verify the identity of a new FNHA client please accept either one piece of primary ID or two pieces of secondary ID to verify that the Status Number provided by the client matches their identity as outlined in [Section 11.1](#).
If a First Nations client has not registered for a Status Card, or has an incorrect status number, please contact FNHA Health Benefits for Assistance at 1-855-550-5454 or email HealthBenefits@fnha.ca.

14.4 Client Eligibility
First Nations Health Authority determines who is eligible for Health Benefits under the Health Benefits Program, but HB Clients will, at a minimum, include those individuals who are:

(a) a status Indian registered pursuant to the Indian Act or a child of less than eighteen months (18) of age, at least one of whose parents is a status Indian; and

(b) a resident of the province of British Columbia within the meaning of the Medical Services Plan; and

(c) not funded or insured for a particular benefit system, or benefit plans provided by:
   (i) federal legislation, a federal policy or under agreements entered into by Canada which fund such a benefit directly or which fund third parties to provide the benefit, excluding employment benefit plans; and/or
   (ii) a First Nations organization pursuant to self-government agreements, land claim agreements, contribution arrangements or internal policies or plans.

Enrollment in the Health Benefits Program is managed by First Nations Health Authority. Enrollment can be verified in PROVIDERnet by using a policy number 40000 and the client’s Status Number or by calling FNHA at 1-855-550-5454.

Note: There are four groups that are not covered by the FNHA because they are in a self-government agreement and have assumed the administration of their own benefits. This includes the following groups:
1) Nisga’a Nation:
   • Gingolx #671 (Kincolith)
   • Gitakdamix #677 (New Aiyanship)
   • Lakalzap #678 (Greenville)
   • Gitwinksilkw #679 (Canyon City)
2) Inuit
3) Mohawks of Akwesasne #159
4) Bigstone Cree #458
14.5 Claiming Procedures
Before beginning treatment, you can view coverage on PROVIDERnet.ca or contact the Pacific Blue Cross (604-419-2000 or toll-free at 1-877-PAC-BLUE) to confirm the patient’s eligibility and coverage information. Claims can be submitted to Pacific Blue Cross on behalf of FNHA clients through EDI and paper.

**Note:** For FNHA clients, enter 40000 in the policy field and enter their Status Number in the ID/Status Number field.

14.6 Check Member Claiming Requirements
The [FNHA Fee Supplement](#) is your guide to claiming requirements for FNHA clients. In the [FNHA Fee Supplement](#) you will find detailed information about which items/services are eligible for reimbursement and whether any additional documentation is required.

14.7 Submitting Supporting Documentation
Pre-determinations can be helpful for providers to know how much a product/service will be reimbursed by the plan and whether there are any specific claiming requirements.

Pacific Blue Cross will accept paper pre-determinations submitted by mail or by fax at 604-419-2601 for FNHA clients. Incomplete claim forms will be rejected and must be resubmitted.

Pre-determinations mailed to Pacific Blue Cross will be responded to by mail. A copy of the Pre-determination will be available to the Client through their Member Profile (under Authorized Products and Services).

If additional documentation is required to process the pre-determination for the expense you are submitting on the Member’s behalf, PBC will reject the pre-determination and provide reasons for the rejection in a custom response message. You may then submit this additional information to PBC as:

1. A new pre-determination with all relevant information, or
2. A revised submission that includes the missing information and references the rejected pre-determination ID number. You may also attach a copy of the EOB statement that they received to indicate that it is a resubmission.
15.0 **Appendix 2: Ministry of Social Development and Poverty Reduction (MSDPR)**

15.1 **Introduction**

The Ministry of Social Development and Poverty Reduction (MSDPR) focuses on providing British Columbians in need with a system of supports to help them overcome social and economic barriers.

15.2 **Overview**

The ministry provides coverage to eligible individuals who receive assistance through the BC Employment and Assistance Program and children in low-income families through the Healthy Kids Program. Individuals eligible for Ministry-sponsored dental coverage can either have coverage for basic dental and denture services with a 2-year limit, or coverage for emergency services only. There are procedures and benefits specific to basic dental and denture service that differ from emergency services coverage only. To understand how the differences between coverages affect claiming procedures, please follow the walkthroughs in Sections 15.7 and 15.8.

For detailed information on coverage types and eligible benefits, refer to the Dental Supplements Dentist/Denturist/Hygienist Fee Schedules.

15.3 **Client Identification**

As outlined in Identifying Blue Cross Members, MSDPR clients will have either a British Columbia Driver’s License or British Columbia Services Card as their identification. This card will contain their Personal Health Number, which is unique to each individual. MSDPR clients must reside in British Columbia. The policy number for MSDPR clients is 13139.

15.4 **Check Eligibility**

Coverage under the Ministry is determined on a month-to-month basis. When determining benefit eligibility, you must always confirm the client is active for the current month.

To confirm the patient’s eligibility, you can either:
- Call Pacific Blue Cross’ Ministry Department (604-419-2000 or toll-free at 1-877-PAC-BLUE), or
- Check on PROVIDERnet.ca.
  - If a person shows as covered through “Now” on PROVIDERnet, that means they have active coverage for the current month.
  - Please refer to the relevant Dental Supplement (Dentist/Denturist/Hygienist) and Schedule of Fee Allowances to find applicable fee codes. You can use the fee code
alongside a client’s PHN to find their coverage in PROVIDERnet.
  - Please refer to the MSDPR FAQ for further information on checking coverage in PROVIDERnet.

15.5 Ministry of Social Development and Poverty Reduction Mailing Address
All pre-determinations and accompanying documentation or claims being submitted by paper for MSDPR clients should be mailed to:

Pacific Blue Cross Ministry Dental Program
PO Box 65339
Vancouver, BC V5N 5P3

15.6 Payment Schedule
All payments are issued bi-weekly and are combined with your regular payment from Pacific Blue Cross.

15.7 Basic Coverage Claiming Procedures
15.7.1 Submitting Supporting Documentation
15.7.1 (a) Non-Emergency Pre-Determinations
For information about submitting pre-determinations for non-emergency MSDPR dental work, please follow the procedures outlined in Section 14.7.

15.7.1 (b) Crowns and Bridges
A predetermination is required for all crown and bridge services prior to the beginning of services (refer to Part E of the Dental Supplement about Crown and Bridgework and Fee Schedule). As not all Ministry clients are eligible for major restorative treatment, eligibility should be confirmed prior to requesting approval for treatment.

It is essential to provide Pacific Blue Cross with all relevant information. Pre-determinations must include the following:

- Crown and/or bridge treatment plan, including tooth numbers and fee codes.
- Current, mounted periapical radiographs of the tooth or teeth involved and bitewing or panorex radiographs showing the remaining dentition.
- A list of the client’s missing dentition.
- A clinical explanation as to necessity. (i.e. why the client’s needs cannot be met through the Basic Dental program.)
- Relevant information regarding the client’s medical condition(s) that would support the need for crown or bridge.
  - The dental condition precludes the use of a removable prosthetic;
  - The person has a physical impairment that makes it impossible to place a removable prosthetic;
  - The person has a cognitive impairment that makes it impossible to assume responsibility for a removable prosthetic.

The pre-determination and accompanying documentation should be mailed to Pacific Blue Cross.

Note: Failure to provide any of the above-noted information will result in the pre-determination being returned and unnecessary delays in adjudicating the request.
15.7.2 Submitting a Claim
15.7.3 (a) Electronic Claiming
If applicable, most claims can be submitted electronically via CDAnet®/DACnet™/CHDAnet™. (refer to Part A of the relevant Dental Supplement (Dentist/Denturist) for detailed information)

15.7.3 (b) Paper Claiming
Claims can be submitted on a standard, computer generated or Pacific Blue Cross claim form.

15.8 Emergency Coverage Claiming Procedures
15.8.1 Submitting a Claim
15.8.1 (a) Electronic Claiming
Overview
Emergency Coverage claims are now able to be resubmitted to Pacific Blue Cross through PROVIDERnet.

Any dental provider who wishes to resubmit Emergency Claims through PROVIDERnet must register for direct deposit to receive electronic statements for the adjudication.

If you submitted a paper claim that was not previously indicated to be an Emergency claim, this can be resubmitted through PROVIDERnet.

The most efficient way to submit an emergency services claim to Pacific Blue Cross is to first submit through CDAnet®/DACnet™. This can be done even if the patient has emergency services only coverage and the claim will not pay initially. Once the claim has been processed (and it has been partially paid or not paid), it will appear in the client’s Claims History in PROVIDERnet.

Please see Section 7.7 for information about signatures on Claim resubmissions.
Emergency Claim Resubmission Walkthrough

To view Claims History, under the Claims tab, select Claim History/Claim Reversal.

You must find the claim you wish to resubmit under Emergency Coverage, then select “Emergency.”

Once you select Emergency, you must confirm that this service was provided for the “immediate relief of pain.”

Reprocess as Dental Emergency

This will then submit the claim to be reprocessed as an Emergency claim.

Once the claim has been resubmitted, if you select “Emergency” again, you will receive confirmation that the claim has been reprocessed. No further action is needed.
Please Note: some claims resubmitted as Emergency may pend for further review.

15.8.1 (b) Paper Claiming
As outlined in the relevant Fee Schedules, Emergency Coverage Claims can be submitted on a standard, computer generated or Pacific Blue Cross dental claim form.

Please Note: Not all fee codes eligible for emergency services coverage will be able to be resubmitted through PROVIDERnet; please submit these claims by paper.
16.0 **Appendix 3: National Blue Cross Plans**

### 16.1 Introduction

**Note:** This information is intended for Providers in British Columbia and Yukon. If you are a dental practitioner in another province, please contact your local Blue Cross office for plan and claim information.

Pacific Blue Cross processes dental claims for Members of national clients living in British Columbia and Yukon. Members of these national plans are issued a unique Blue Cross identification card. When a Member presents this card to your office, accept it as a valid Pacific Blue Cross Dental ID card and send the claims to Pacific Blue Cross for processing.

### 19.2 Claiming Procedures

For patients with more than one national or Pacific Blue Cross plan, submit one claim form only. For patients whose additional coverage is with another health benefits carrier, a copy of the primary carrier’s Explanation of Benefits is required with your claim form submission. Coverage information for the second plan must be included on your claim form submission. Please refer to the *Coordination of Benefits (COB)* section of this guide for more information on submitting these types of claims.

### 19.3 To Transmit Claims Using CDAnet®/DACnet™ (Dentist/Denturist Only)

National plan claims are transmitted the same way as standard Pacific Blue Cross claims. The only difference is in how you enter the identification and group policy numbers:

In the Primary Policy Plan Number field, omit the two leading zeros and enter the remaining eight digits of the policy number exactly as shown on the card (e.g. 93900001). Leave the Division Number field blank. In the ID Number field, enter the 11-digit identification number the same way as you would the standard Pacific Blue Cross ID number (e.g. 12345678900). Some software may require entering the first nine digits into the ID Number field and the last two digits into the Dependent Number field.

Your office has 30 days from the date of service to submit a national claim through CDAnet®/DACnet™.

### 16.4 To Submit Claims Using a Paper Claim Form

National plan claims require the same information as standard Pacific Blue Cross claims. The only difference is in how you enter the identification and group policy numbers:

Write all 10 digits of the policy number in the Group Number section and all 11 digits of the identification number in the ID Number section.
### 17.0 Appendix 4: Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Agreement</td>
<td>Means an Agreement between Pacific Blue Cross and a group, plan sponsor, or Subscriber under which Blue Cross administers a supplementary health benefits plan for eligible Health Benefits.</td>
</tr>
<tr>
<td>British Columbia Driver’s License</td>
<td>The driver’s license that (a) is issued by ICBC on or after February 10, 2013, as indicated on the license, to a person in accordance with the Motor Vehicle Act, and (b) contains the person's Personal Health Number, and includes a duplicate of that license, as issued under section 33 of the Motor Vehicle Act.</td>
</tr>
<tr>
<td>British Columbia Services Card with</td>
<td>The physical credential that (a) is issued to a person on enrolment, or renewal of enrolment, with the plan, and (b) contains the person's Personal Health Number and includes a replacement or a duplicate of that card, as issued by a provincial identity information services Provider.</td>
</tr>
<tr>
<td>Personal Health Number</td>
<td></td>
</tr>
<tr>
<td>Business Owner</td>
<td>A Business Owner is an individual or entity who owns a business. Business owners acknowledge accountability for any claims that are submitted, whether personally or by licensed healthcare professionals, duly registered staff, qualified employees, subcontractors, or independent contractors working at their clinic, and paid to themselves or their business by Pacific Blue Cross.</td>
</tr>
<tr>
<td>Claim</td>
<td>A request for payment submitted by a Provider to Pacific Blue Cross for dental services to Members and/or clients in accordance with the Agreement, Reference Guide, and policies of the Program.</td>
</tr>
<tr>
<td>Client</td>
<td>A person who is eligible to receive benefits from the First Nations Health Authority, and/or the Ministry of Social Development and Poverty Reduction, and/or the Ministry of Children and Family Development in accordance with the eligibility criteria in the relevant sections of this Reference Guide.</td>
</tr>
<tr>
<td>Close Relative</td>
<td>A spouse, child, brother, sister, parent, grandparent or grandchild of a Member.</td>
</tr>
<tr>
<td>Coordination Co-ordination of Benefits</td>
<td>This is applicable if a Member is covered by more than one health plan. If the plan does not pay the full amount of an expense, the claim can be submitted to the other plan for the balance.</td>
</tr>
<tr>
<td>(COB)</td>
<td></td>
</tr>
<tr>
<td>Co-payment</td>
<td>A portion of an insured’s medical costs that must be paid by the insured as a condition of the insurer paying the remaining portion.</td>
</tr>
<tr>
<td>Deductible</td>
<td>Means the amount the Member must pay before Blue Cross will make any benefit payments under a policy.</td>
</tr>
</tbody>
</table>
| **Dependent** | Means any of the following individuals:  
1. One spouse of the Member.  
2. Any unmarried child, stepchild, legally adopted child, or legal ward (not a foster child) under 21 and financially dependent on the Member or the Spouse.  
3. Unmarried child under 25 who is in full-time attendance at a recognized educational institute.  
4. Any unmarried disabled child who is living with and is financially dependent on the Member and/or Spouse. |
<p>| <strong>Explanation of Benefits (EOB)</strong> | Explanation of benefits is a written statement displaying all the details of the claims paid and not paid resulting from a request. EOBs can be issued on Paper or Electronically. |
| <strong>Government plan</strong> | Means the health, drug, and dental benefit coverage that Canadian federal, provincial and/or territorial governments provide for their residents, including any plan that provides insurance as required by statute, but does not mean group benefit plans provided to government employees. |
| <strong>Member</strong> | The person, having coverage who has a direct relationship with the Contract holder or the Participating Employer. |
| <strong>British Columbia Personal Health Number (PHN)</strong> | A unique lifetime identifier for health care in British Columbia. PHN remains the same, regardless of any changes to a resident’s personal status. |
| <strong>Personal Information</strong> | Means any information about an identifiable individual. |
| <strong>Practitioner</strong> | Means a person legally licensed, certified, or registered to practice a profession by the appropriate licensing, certification, or registration authority in the jurisdiction where the care or services are provided and acting within the scope of that license. Where no such authority exists, the person has a certificate of competency from the professional provincial or national body, which establishes standards of competence and conduct for that profession. This excludes a Practitioner residing with or related to the Member or Dependent. We reserve the right to refuse the service, medical supply, or equipment from the Practitioner based on ineligibility, or based on the Practitioner’s qualifications or conduct. |
| <strong>Prescription</strong> | Means a written order for the use of a medicine, treatment, product or service by an eligible prescriber in accordance with the terms of the Benefit Agreement. |
| <strong>Primary Administrator</strong> | In PROVIDERnet, this is a person who has access to add/edit banking information and who also has access to submit an electronic claim. |
| <strong>Provider</strong> | Means a person, group, or other entity currently licensed, certified, or registered to provide an eligible service, medical supply, or equipment by the appropriate licensing, certification, or registration authority in the jurisdiction where the services or equipment are provided or, where no such authority exists, has a certificate of competency from the professional body which establishes standards of competence and conduct for the profession, and is acting within the scope of that license. We reserve the right to refuse the service, medical supply or equipment from the Provider based on ineligibility or based on the Provider’s qualifications or conduct. |
| <strong>Provider Number</strong> | A unique reference number assigned to the Provider as identification to facilitate the submission of claims for adjudication and to receive payment. |</p>
<table>
<thead>
<tr>
<th>Qualified Staff</th>
<th>Staff who are qualified for the given purpose and have complied with specific requirements.</th>
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</thead>
<tbody>
<tr>
<td><strong>Standard Administrator</strong></td>
<td>In PROVIDERnet, this is a secondary account to the Primary Administrator account. They can submit claims on the Primary Administrator’s behalf; they do not have access to updating banking information and cannot view claim statements.</td>
</tr>
<tr>
<td><strong>Store</strong></td>
<td>A business that sells products to the public for use or consumption rather than for resale.</td>
</tr>
</tbody>
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