# Table of Contents

Table of Contents ............................................................................................................. 2
1.0 Introduction .................................................................................................................. 6
2.0 About Pacific Blue Cross ............................................................................................. 6
3.0 Blue Cross Plans .......................................................................................................... 7
  3.1 Plans .......................................................................................................................... 7
4.0 Identifying Blue Cross Members .................................................................................. 8
  4.1 Overview .................................................................................................................. 8
  4.2 Pacific Blue Cross Identification Cards ................................................................... 8
  4.3 Status Cards ............................................................................................................ 8
  4.4 Personal Health Number (PHN) ............................................................................. 8
  4.5 National Blue Cross Identification Cards .............................................................. 9
5.0 Pacific Blue Cross – Claims Submission Channels ..................................................... 10
6.0 Becoming a Pacific Blue Cross Provider .................................................................... 11
  6.1 Overview ................................................................................................................ 11
  6.2 Pacific Blue Cross Hearing Provider Requirements .............................................. 11
  6.3 Qualified Staff ......................................................................................................... 11
  6.4 How to Register as a Pacific Blue Cross Hearing Provider .................................... 12
  6.5 Helpful PROVIDERnet® Terminology .................................................................. 12
7.0 About PROVIDERnet .................................................................................................... 14
  7.1 Overview ................................................................................................................ 14
  7.2 Technical Requirements ......................................................................................... 14
  7.3 Activate your PROVIDERnet Account ................................................................... 14
  7.4 Set up Direct Deposit .............................................................................................. 16
  7.5 Keeping Your Information up to Date ..................................................................... 16
  7.6 Forgot Your Password? .......................................................................................... 16
8.0 Claiming Procedures .................................................................................................... 18
  8.1 Overview ................................................................................................................ 18
  8.2 Provider-Submitted Claims Submission Channels ............................................... 18
  8.3 PROVIDERnet Claiming ......................................................................................... 18
    8.3.1 Overview .......................................................................................................... 18
    8.3.2 Check Member Eligibility ................................................................................ 18
    8.3.3 Check Member Claiming Requirements ......................................................... 18
    8.3.4 Submitting Supporting Documentation ......................................................... 19
    8.3.5 Pay Provider Authorization ............................................................................ 19
    8.3.6 Submitting a Claim .......................................................................................... 20
    8.3.7 Payment Schedule .......................................................................................... 23
    8.3.8 Claim History .................................................................................................. 23
    8.3.9 Reverse a Claim .............................................................................................. 24
    8.3.10 Claim Statements .......................................................................................... 25
    8.3.11 Unable to Submit a Claim Through PROVIDERnet? .................................... 25
  8.4 Paper Claiming .......................................................................................................... 26
    8.4.1 Overview .......................................................................................................... 26
    8.4.2 Check Eligibility .............................................................................................. 26
    8.4.3 Check Member Claiming Requirements ......................................................... 26
    8.4.4 Submitting Supporting Documentation ......................................................... 26
    8.4.5 Pay Provider Authorization ............................................................................ 26
    8.4.6 Submitting a Claim .......................................................................................... 27
    8.4.7 Payment Schedule .......................................................................................... 27
    8.4.8 Claim History .................................................................................................. 27
    8.4.9 Reverse a Claim .............................................................................................. 27
    8.4.10 Claim Statements .......................................................................................... 27
  8.5 Assignment of Payment (AOP) .................................................................................. 28
<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.5.1</td>
<td>Overview</td>
<td>28</td>
</tr>
<tr>
<td>9.0</td>
<td>Coordination of Benefits (COB)</td>
<td>29</td>
</tr>
<tr>
<td>9.1</td>
<td>Guidelines</td>
<td>29</td>
</tr>
<tr>
<td>9.2</td>
<td>External COB</td>
<td>30</td>
</tr>
<tr>
<td>9.3</td>
<td>Dual Blue Cross Coverage</td>
<td>31</td>
</tr>
<tr>
<td>9.4</td>
<td>Provide all COB Information</td>
<td>32</td>
</tr>
<tr>
<td>9.5</td>
<td>Some Plans May Not Allow COB</td>
<td>32</td>
</tr>
<tr>
<td>9.6</td>
<td>Some Plans are Always Primary</td>
<td>32</td>
</tr>
<tr>
<td>9.7</td>
<td>Some Plans are Always Secondary</td>
<td>32</td>
</tr>
<tr>
<td>10.0</td>
<td>Pacific Blue Cross Claim Statements</td>
<td>33</td>
</tr>
<tr>
<td>10.1</td>
<td>Overview</td>
<td>33</td>
</tr>
<tr>
<td>10.2</td>
<td>Sample Statement</td>
<td>34</td>
</tr>
<tr>
<td>11.0</td>
<td>Fraud Prevention</td>
<td>35</td>
</tr>
<tr>
<td>11.1</td>
<td>Help Prevent Identity Fraud</td>
<td>35</td>
</tr>
<tr>
<td>11.2</td>
<td>Whistleblower Hotline</td>
<td>35</td>
</tr>
<tr>
<td>12.0</td>
<td>Provider Guidelines</td>
<td>36</td>
</tr>
<tr>
<td>12.1.1</td>
<td>Legal Terms and Conditions</td>
<td>36</td>
</tr>
<tr>
<td>12.1.2</td>
<td>Terms and Conditions for Submitting Claims Online</td>
<td>36</td>
</tr>
<tr>
<td>12.1.3</td>
<td>PROVIDERnet – Member Consent and Declaration</td>
<td>36</td>
</tr>
<tr>
<td>12.2</td>
<td>Payment of Claims</td>
<td>36</td>
</tr>
<tr>
<td>12.2.1</td>
<td>Partial Payment</td>
<td>36</td>
</tr>
<tr>
<td>12.2.2</td>
<td>Billing and Co-Payment</td>
<td>36</td>
</tr>
<tr>
<td>12.2.3</td>
<td>Insured and Non-Insured Charges</td>
<td>37</td>
</tr>
<tr>
<td>12.2.4</td>
<td>Claiming Deadline</td>
<td>37</td>
</tr>
<tr>
<td>12.2.5</td>
<td>Items not Picked Up</td>
<td>37</td>
</tr>
<tr>
<td>12.2.6</td>
<td>Missed Appointments</td>
<td>37</td>
</tr>
<tr>
<td>12.2.7</td>
<td>Overpayment/Adjustment</td>
<td>37</td>
</tr>
<tr>
<td>12.2.8</td>
<td>Currency</td>
<td>37</td>
</tr>
<tr>
<td>12.3</td>
<td>Relatives</td>
<td>37</td>
</tr>
<tr>
<td>12.4</td>
<td>Confidentiality of Personal Information</td>
<td>37</td>
</tr>
<tr>
<td>12.5</td>
<td>Indemnity</td>
<td>37</td>
</tr>
<tr>
<td>12.6</td>
<td>Intellectual Property</td>
<td>38</td>
</tr>
<tr>
<td>12.7</td>
<td>Endorsements</td>
<td>38</td>
</tr>
<tr>
<td>12.8</td>
<td>Assignment</td>
<td>38</td>
</tr>
<tr>
<td>12.9</td>
<td>Amendment</td>
<td>38</td>
</tr>
<tr>
<td>12.10</td>
<td>Termination of Pay Direct Privilege</td>
<td>38</td>
</tr>
<tr>
<td>13.0</td>
<td>Audit</td>
<td>39</td>
</tr>
<tr>
<td>13.1</td>
<td>Background</td>
<td>39</td>
</tr>
<tr>
<td>13.2</td>
<td>Audit Performance</td>
<td>39</td>
</tr>
<tr>
<td>13.3</td>
<td>Audit Selection</td>
<td>39</td>
</tr>
<tr>
<td>13.4</td>
<td>Audit Notification</td>
<td>39</td>
</tr>
<tr>
<td>13.5</td>
<td>Auditor Access</td>
<td>40</td>
</tr>
<tr>
<td>13.6</td>
<td>Confidentiality</td>
<td>40</td>
</tr>
<tr>
<td>13.7</td>
<td>Auditable Records</td>
<td>40</td>
</tr>
<tr>
<td>13.8</td>
<td>Disallowed Claims</td>
<td>40</td>
</tr>
<tr>
<td>13.9</td>
<td>Result Letter</td>
<td>40</td>
</tr>
<tr>
<td>14.0</td>
<td>Appendix 1: First Nations Health Authority – Effective September 16, 2019</td>
<td>42</td>
</tr>
<tr>
<td>14.1</td>
<td>Introduction</td>
<td>42</td>
</tr>
<tr>
<td>14.2</td>
<td>Overview</td>
<td>42</td>
</tr>
<tr>
<td>14.3</td>
<td>Client Identification</td>
<td>42</td>
</tr>
<tr>
<td>14.4</td>
<td>Client Eligibility</td>
<td>43</td>
</tr>
<tr>
<td>14.5</td>
<td>Claiming Procedures</td>
<td>43</td>
</tr>
<tr>
<td>14.5.1</td>
<td>Overview</td>
<td>43</td>
</tr>
<tr>
<td>14.5.2</td>
<td>Check Member Claiming Requirements</td>
<td>43</td>
</tr>
<tr>
<td>14.5.3</td>
<td>Submitting Supporting Documentation</td>
<td>43</td>
</tr>
<tr>
<td>14.5.4</td>
<td>Submitting a Claim</td>
<td>44</td>
</tr>
</tbody>
</table>
15.0 Appendix 2: Ministry of Social Development and Poverty Reduction (MSDPR) .............................. 45
15.1 Introduction ..................................................................................................................... 45
15.2 Overview ....................................................................................................................... 45
15.3 Client Identification ....................................................................................................... 45
15.4 Claiming Procedures ..................................................................................................... 45
  15.4.1 Overview ................................................................................................................ 45
  15.4.2 Check Member Eligibility ..................................................................................... 45
  15.4.3 Check Claiming Requirements .............................................................................. 45
  15.4.4 Submitting Supporting Documentation ................................................................. 46
  15.4.5 Submitting a Claim ............................................................................................... 46
  15.4.6 Payment Schedule ............................................................................................... 47
15.5 Overpayment .................................................................................................................. 47
15.6 Audit of Records/Files .................................................................................................... 47
16.0 Appendix 3: Glossary ...................................................................................................... 48
## Version History

<table>
<thead>
<tr>
<th>Version</th>
<th>Modified/Effective Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>• Updates to FNHA Client Eligibility section, FNHA Submitting</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Supporting Documentation section</td>
</tr>
</tbody>
</table>
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 70 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 1.4 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 will administer medical supply and equipment, vision, hearing, dental and some pharmacy 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) clients as identification.

**FNHA Policy Number:** 40000

For further information on about FNHA client identification and eligibility see the [FNHA Section](#).

### 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.

**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 Pacific Blue Cross – Claims Submission Channels

There are many ways Providers can submit claims for Pacific Blue Cross Members. To help you understand current capabilities, please refer to the table below for an overview of claims submission channels.

Be sure to check this section for updates.

Current state of Hearing claims submission channels:

<table>
<thead>
<tr>
<th>Claims Submission Channels</th>
<th>Pacific Blue Cross Plans</th>
<th>MSDPR</th>
<th>FNHA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 PROVIDERnet</td>
<td>✗</td>
<td>✗</td>
<td>✓</td>
</tr>
<tr>
<td>2 Paper Submission</td>
<td>✗</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>3 Assignment of Payment</td>
<td>✓</td>
<td>✗</td>
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<tr>
<td>4 Customer Pays Provider</td>
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<td>✓</td>
</tr>
</tbody>
</table>

1. As outlined in the table, PROVIDERnet is currently only available to you when you are supporting First Nations Health Authority (FNHA) clients.

2. Paper submission is currently available to you when you are supporting the Ministry of Children and Families (MCFD), Ministry of Social Development and Poverty Reduction (MSDPR), and First Nations Health Authority (FNHA) clients.

3. Assignment of Payment is available to you when you are supporting Pacific Blue Cross (PBC) Members and FNHA clients and there is an element of financial hardship involved, or the claim is over $1,000.

4. Customer Pays Provider is available for PBC Members and for FNHA clients. Once the customer has paid the Provider, they can submit their claim to Pacific Blue Cross.
6.0 Becoming a Pacific Blue Cross Provider

6.1 Overview
Becoming a Pacific Blue Cross Provider allows you to submit claims to Pacific Blue Cross on behalf of your eligible customers. This helps increase your customers’ convenience and satisfaction and increases your business’ efficiency.

All applications to become a Pacific Blue Cross Provider are reviewed for Provider-specific requirements.

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

6.2 Pacific Blue Cross Hearing Provider Requirements
Pacific Blue Cross registers the Provider store location and issues a Pacific Blue Cross Provider number. To register as a Hearing Provider, you must have at least one of the following registered staff in your employment:

- Audiologist
- Hearing Instrument Practitioner

To receive standing as a Hearing Provider, you must include a copy of the appropriate certification of all registered staff.

6.3 Qualified Staff
The Provider verifies that their staff are duly registered under the laws of their province or territory to practice (if applicable); or they are qualified for the given purpose and having complied with specific requirements (if applicable).

The Provider agrees to advise Pacific Blue Cross as soon as reasonably possible if:
- their qualified staff are no longer in their employment, or
- their duly registered staff are no longer registered to practice with their regulatory college, or
- their duly registered staff have limits or conditions placed on their registration.

Pacific Blue Cross will not pay (or will recover payments through an Audit) for services rendered by a Provider whose staff:
- are not appropriately qualified or duly registered to practice,
- provide services outside of their scope of practice,
- contravene any applicable Provincial or Federal legislation, or any generally accepted standards of practice established by the Provider’s Association,
- provide services outside of any limits and conditions on their practice.
6.4 How to Register as a Pacific Blue Cross Hearing Provider

Visit providernet.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 to avoid delays.

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

- A current copy of the store’s business license.
- A copy of the certificate of all duly registered staff (e.g. Audiologist’s college certificate).
- Name and contact information of the corporate contact.

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.

- If your application is successful we will issue you a Provider ID. This ID is unique to your Provider Office. Each location of a chain store requires its own Provider ID.
  - Your Provider ID and temporary password will be sent to the email you provided on your application. You will then need to activate your account in PROVIDERnet. This is explained further in Section 7.3.
- If your application is denied, you will be emailed the reason and may re-apply (if applicable).

6.5 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.

Business Owners: Business owners acknowledge accountability for any claims that are submitted online by themselves, 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. Business owners must agree to the PROVIDERnet Terms and Conditions before claims can be submitted to Pacific Blue Cross through PROVIDERnet.

Primary Administrator: A person who has access to add/edit banking information and who also has access to submit an electronic claim through PROVIDERnet.

Examples: Office manager, business owner, front desk staff (if applicable)

Provider: This refers to the physical store.

Examples: ABC Hearing on Main Street
Standard Administrator: This is an optional 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.

Examples: Front desk staff, any staff member

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.
7.0 About PROVIDERnet

7.1 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 submit claims on behalf of Members, 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.

⚠️ Please note: Online Claiming will only be available for FNHA clients starting September 16th, 2019.

7.2 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.

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

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.
### 7.4 Set up Direct Deposit

Setting up Direct Deposit must be completed by the Primary Administrator prior to submitting the first electronic claim.

**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**.

**Note:** Hearing Providers can only have one bank account attached to each Provider number.

### 7.5 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](http://providernet.ca) and click **Make UPDATES to your account** for the following:

- Closing a Provider Office
- Change of Address
- Change of Office Name

### 7.6 Forgot Your Password?

If you have forgotten your password to log in to PROVIDERnet, go to the [login page](http://providernet.ca) 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.
8.0 Claiming Procedures

8.1 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.

8.2 Provider-Submitted Claims Submission Channels
There are a variety of ways for Providers to submit claims to Pacific Blue Cross. How you are able to submit a claim can depend on the policies and requirements of the Member’s plan. Some plans allow pay-Provider claims submission and some do not; claims submission channels can be classified based on this distinction.

If you are assisting a Member whose plan allows pay-Provider, the following options are available:

- Electronic claims submission through PROVIDERnet
- Manual claims submission through paper

If you are assisting a Member whose plan only allows pay-Member, the following options are available:

- Claims submission through the Assignment of Payment form

Please see Section 5.0 of this guide for an overview of different plan types.

8.3 PROVIDERnet Claiming

8.3.1 Overview
Once you have registered for a PROVIDERnet account and set up your direct deposit information, you will be able to submit eligible claims electronically and receive real time responses.

**Note:** Hearing Provider e-claims can be submitted only for certain policies. See Section 5.0 for further information.

8.3.2 Check Member Eligibility
The easiest way to assess Member eligibility is to submit and reverse a claim in PROVIDERnet. This is only applicable to plans that have the capability to submit through PROVIDERnet.

To learn about submitting a claim through PROVIDERnet, see Section 8.3.6, and to learn about reversing a claim in PROVIDERnet, see Section 8.3.9.

For plans that have specific claiming requirements (such as FNHA and MSDPR), Member eligibility can also be confirmed by calling Pacific Blue Cross at 604-419-2000 or toll-free at 1-877-PAC-BLUE.

8.3.3 Check Member Claiming Requirements
Some plans may have specific claiming requirements. Please review all available plan information to understand what documentation may be required as part of claiming requirements. Plans with specific claiming requirements will be published on our website at providernet.ca or made specific reference to in this guide.

Plans such as MSDPR and FNHA have specific claiming requirements; please see the FNHA Fee Supplement for further information.
8.3.4 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 pre-determinations submitted by paper. You can mail these pre-determinations directly to us. Incomplete pre-determinations forms will be rejected and must be resubmitted.

- Fill out a **Standard Health Claim Form** with “pre-determination” written on top
- Include a full quote for the product or service
- Ensure all supporting medical documents are included
- Fill in the form and print it; if you are filling it in by hand please use blue or black ink only
- Mail the documents to Pacific Blue Cross

Pre-determinations mailed to Pacific Blue Cross will be responded to by mail. A copy of the Pre-determination will be sent the client on 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 can submit this additional information to PBC as:

1) A new pre-determination with all relevant information, or
2) Submit the missing information and reference the rejected pre-determination ID number and/or attach a copy of the EOB statement that they received so the examiner knows it’s a resubmission.

8.3.5 Pay Provider Authorization
Prior to Providers submitting claims, Member consent must be attained. Members must authorize Providers to direct bill Pacific Blue Cross on their behalf for the products and/or services provided. Download the **Pay Provider Authorization Form** and complete all required information prior to providing the products and/or services.

You must receive one **Pay Provider Authorization Form** per Member/Dependent prior to you submitting a claim on their behalf. This only needs to be completed once and is valid for the period that a Member/Dependent is your customer. The form must be kept on file for a minimum of three (3) years from the last date of claim submission on the Member/Dependent’s behalf.

The form must be made available to Pacific Blue Cross upon request. During the course of an audit, if a requested form is not available, the corresponding claim payment will be subject to review and possible adjustment.
8.3.6 Submitting a Claim

Once you have successfully set up your banking information and received a signed Pay Provider Authorization Form, you are ready to submit an electronic claim for Pacific Blue Cross Members.

Sign In
At providernet.ca, sign in to your account.

Preparing the Claim
Navigate to the Claims tab menu option and select Submit a claim.

Enter the Member’s Policy and ID/Status Numbers.

Click Search.

A list of the eligible Members for the policy and ID/Status Number will appear.

Validate the Member’s identity with their first name, last name and birthdate with the information provided on their identification.
When you are entering a claim, you will have to select from one of the following options.

- The services provided are related to an ICBC or other auto insurance case.
- The services provided are related to a WorkSafe case (WSBC).
- The services provided are related to an accident.
- The illness or injury being treated is **not related** in any way to a motor vehicle incident, workplace incident, or any other accident where ICBC, WorkSafe BC, or any other liable third party may become involved.

The only claims that you can submit in PROVIDERnet are for illness or injury that are **not related** to motor vehicle accidents, workplace accidents, or any other accidents.

**Member Expenses**

Complete the required information to submit a claim.

- Claimant
- Benefit
- Type of expense
- Date of purchase/service
- Amount Claimed (this is the total invoice amount for the expense)
- Amount paid by public or provincial plan
- Amount paid by other insurance company (see Section 9.0)
- Nature of illness/injury

Select the checkbox if the patient has provided you with a physician’s referral. Some plans may require this for payment. Keep this information on file. Pacific Blue Cross reserves the right to request a copy in the future. If the claim rejects and you forgot to select, you can resubmit the claim again.

Click **Next**.
**8.0 Claiming Procedures**

**Review Details and Submit**
This screen will allow you to review the information you have submitted. To edit the claim you have just entered, click on the pencil icon. To delete this claim, select the trash can.

Some plans allow you to submit multiple claims at once. These claims can be for the Member or another family Member on the same plan.

Other plans are based on individual coverage and require you to submit claims for one Member at a time.

Once you are satisfied with the claim detail information, click the check box to confirm that all the information is correct, and you have read and agreed to the Member Consent and Declaration.

Click Submit.

**Processed Claim**
You will receive a confirmation and Claim ID from Pacific Blue Cross within seconds of your submission. You can print this page for your records.

This claim (alongside paper claims submitted and processed) is visible in your PROVIDERnet Claim History screen.

Plan Members can also view their claim history in Member Profile as well. (Member Profile is not available for MSDPR clients).

![Claim History Screen](image)

**Note:** The Member may request that you print a copy of this screen if they have to submit to another insurance carrier as part of their Coordination of Benefits.

**Pended Claim**
From time to time, a claim may be pended for further information.

You can request the Member pay upfront and submit a claim to Pacific Blue Cross themselves. You should then cancel the claim you have submitted on their behalf. This process is similar to reversing a claim. (See Section 8.3.9).

You can also check back to see when the claim’s pend status is resolved and bill the Member the remaining balance if applicable.
8.3.7 Payment Schedule
Payment cut off is every Friday at midnight. Electronic Funds Transfers (EFTs) will be released on Mondays and may take up to three business days to be deposited to your account.

8.3.8 Claim History
Navigate to the Claims tab menu option and select Claim History/Claim Reversal.

These next screens will allow you to review all of the claim details you have submitted, as well as reverse any claims that may have been processed in error.

Examples of errors may include but are not limited to:
- Incorrect Member
- Incorrect dollar amount
- Incorrect expense/Item
- Incorrect service date

Claim History
Depending on your administrative needs, you can search through your claims in different ways. You can look at all the claims in a preset date range, within a specific date range, or by the Claim ID number.

View Details
You can view the details of an Expense/Item by clicking on the Details button.

Reviewing the Claim Details will also allow you to see Eligible amounts, Deductible, Co-payments, and Paid Amounts.

You can also view if another carrier paid or another Pacific Blue Cross Policy paid any portion of the Expense/Item.
8.3.9 Reverse a Claim

If you need to reverse a claim, you must be in the claim history screen. (Follow the steps outlined in Section 8.3.8 to navigate to this screen.)

Once you have navigated to the specific claim you would like to reverse, click on Reverse Claim.

Claims can only be reversed if the button is activated.

You have one year from the date of service to reverse a claim.

Confirmation of Reversal

Confirm the claim you want to reverse.

Click Reverse.

Once you have successfully reversed your claim, you will receive a message.
View Reversals
After you have reversed a claim, if you return to search Claim History, the claim will now appear as having a negative amount paid.

<table>
<thead>
<tr>
<th>Service Date</th>
<th>Name</th>
<th>Expense/Item</th>
<th>Provider</th>
<th>Practitioner</th>
<th>Amount Claimed</th>
<th>Amount Paid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar 12, 2019</td>
<td>John Doe</td>
<td>27003-Hearing Aid - Right Ear</td>
<td>HEARING SERVICES</td>
<td></td>
<td>$1,005.00</td>
<td>- $1,005.00</td>
</tr>
<tr>
<td>Mar 12, 2019</td>
<td>John Doe</td>
<td>27004-Hearing Aid - Left Ear</td>
<td>HEARING SERVICES</td>
<td></td>
<td>$1,005.00</td>
<td>$1,005.00</td>
</tr>
</tbody>
</table>

8.3.10 Claim Statements
Once you sign up for direct deposit, you will automatically switch from paper to electronic statements. An email will be sent to the Primary Administrator’s email address to advise you when the statement is ready to view in PROVIDERnet. To access your PDF statement:

Click on the Claims tab, then click Claim Statements.

Use the Published date range to search and then click Retrieve.

Click View to open the PDF claim statement.

8.3.11 Unable to Submit a Claim Through PROVIDERnet?
Some plans may have items that you are unable to submit through PROVIDERnet.

Please do not try to substitute different codes or items if you are unable to submit a claim through PROVIDERnet.

If you are not able to submit a claim for an eligible item through PROVIDERnet, it must be submitted by mail (if supported by the applicable plan provisions).
8.4 Paper Claiming
8.4.1 Overview
Providers can choose to submit claims by paper. You can mail these claims directly to us. Incomplete claim forms will be rejected and must be resubmitted.

Please mail your claims to:

Pacific Blue Cross / BC Life
PO Box 7000
Vancouver, BC V6B 4E1

**Note:** Paper claims can be submitted only for certain policies. See **Section 5.0** for further information.

8.4.2 Check Eligibility
To check a Member’s eligibility, you may phone us at 604-419-2000 or toll-free at 1-877-PAC-BLUE. Please have the Member’s policy and ID/Status numbers ready when you call.

8.4.3 Check Member Claiming Requirements
Some plans may have specific claiming requirements. Please review all available plan information to understand what documentation may be required as part of claiming requirements.

Plans such as MSDPR and FNHA sometimes have specific claiming requirements; please see the [FNHA Fee Supplement](#) for further information.

8.4.4 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 pre-determinations submitted by paper. You can mail these pre-determinations directly to us. Incomplete forms will be rejected and must be resubmitted.

- Fill out a [Standard Health Claim Form](#) with “pre-determination” written on top
- Include a full quote for the product or service
- Ensure all supporting medical documents are included
- Fill in the form and print it; if you are filling it in by hand please use blue or black ink only
- Mail the documents to Pacific Blue Cross

Pre-determinations mailed to Pacific Blue Cross will be responded to by mail. A copy of the Pre-D will be sent to the Provider and will be available to the client on 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 can submit this additional information to PBC as:

1) A new pre-determination with all relevant information, or
2) Submit the missing information and reference the rejected pre-determination ID number and/or attach a copy of the EOB statement that they received so the examiner knows it’s a resubmission.

8.4.5 Pay Provider Authorization
Prior to Providers submitting claims, Member consent must be attained. Members must authorize Providers to direct bill Pacific Blue Cross on their behalf for the products and/or services provided. Download the [Pay Provider Authorization Form](#) and complete all required information prior to providing the products and/or services.
You must receive one Pay Provider Authorization Form per Member/Dependent prior to you submitting a claim on their behalf. This only needs to be completed once and is valid for the period that a Member/Dependent is your customer. The form must be kept on file for a minimum of three (3) years from the last date of claim submission on the Member/Dependent’s behalf.

The form must be made available to Pacific Blue Cross upon request. During the course of an audit, if a requested form is not available, the corresponding claim payment will be subject to review and possible adjustment.

8.4.6 Submitting a Claim
To ensure prompt payment, please follow the steps outlined on the applicable claim form.

See the FNHA - Health Claim/Pre-determination Form and/or the MSDPR Hearing Instrument Form for examples of paper claim forms.

8.4.7 Payment Schedule
Payment cut off is every Friday at midnight. Cheques are sent by Canada Post every Monday.

8.4.8 Claim History
If you would like to inquire about your claim history, please call us at 604-419-2000 or toll-free at 1-877-PAC-BLUE and a Customer Service Representative can assist you with your request.

8.4.9 Reverse a Claim
To reverse a claim, you can submit a copy of your statement to us with a note requesting a reversal with an explanation, or you can call us at 604-419-2000 or toll-free at 1-877-PAC-BLUE.

8.4.10 Claim Statements
Your claim statements will be mailed to you weekly.
8.5 Assignment of Payment (AOP)

8.5.1 Overview

Assignment of Payment (AOP) is a service that Pacific Blue Cross offers on an exception basis only for:
  - reimbursement plans to Members with financial hardship, or
  - when an item’s cost exceeds $1,000, or
  - for plans that do not allow pay-Provider relationships.

While it is at the Provider’s discretion whether to enter into this arrangement, it is important to note that the Provider agrees to provide the product prior to the manual submission to Pacific Blue Cross.

It is the customer’s responsibility to follow these steps:

1. Contact the Pacific Blue Cross Customer Service Department to request an AOP on a one-time exception basis due to financial hardship, or because the item is over $1,000. The form is also available on our website.

2. If the expense (in excess of $1,000) is required on a regular basis and therefore an on-going AOP is required; the Member must submit this request, in writing to Pacific Blue Cross stating the reason for the request. Pacific Blue Cross will provide a decision in writing to the customer and the on-going AOP, if approved.

3. By signing the AOP form, the customer takes full responsibility for any portion not covered by the plan. The Provider is obligated to bill the full balance to the customer. Any discounting to the expense must be done prior to submission to Pacific Blue Cross. Discounting on the balance not covered by the plan is not acceptable and is subject to audit recovery.

AOP Claim Submission

Pacific Blue Cross requires the completed AOP form to be mailed back along with the original receipt. Pacific Blue Cross will adjudicate the claim in accordance with the plan and issue payment directly to the Provider, and the balance must be billed to the patient.

AOPs must be submitted with an original receipt that must indicate the total value being claimed as the "Member pays" amount. Receipts should not have a value as "PBC pays" amount if the claim has not been adjudicated through any Pacific Blue Cross plan.

Please note incomplete AOP forms will be rejected and must be resubmitted. The claim must be resubmitted with all required information and received at Pacific Blue Cross within the plan’s claiming deadline.

Claims received past the plan’s specific deadline will not be considered. Please contact Pacific Blue Cross to confirm the claiming deadline of a specific plan.
9.0 Coordination of Benefits (COB)

9.1 Guidelines
Pacific Blue Cross bases COB rules on 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:
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.
9.2 External COB
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.
### 9.3 Dual Blue Cross Coverage

Pacific Blue Cross is in the process of updating pay-Provider capabilities. If the Member has Dual Pacific Blue Cross coverage, please follow COB claiming process below.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Coverage:</strong></td>
<td><strong>Primary Coverage:</strong></td>
<td></td>
<td><strong>Primary Coverage:</strong></td>
</tr>
<tr>
<td>PACIFIC BLUE CROSS</td>
<td>MINISTRY</td>
<td></td>
<td>MINISTRY</td>
</tr>
</tbody>
</table>

**Provider Submits One Claim to PBC with Primary Policy & 3B and CoB with FNHA Policy & 3B**

- Provider submits One Claim to PBC using MSEP form.
- PBC policy 3B indicates COB with FNHA policy 4000.
- PBC receives EOB from PBC for both Ministry & PBC Coverage.
- PBC forwards claim to FNHA.
- FNHA receives EOB from PBC for both Ministry & FNHA Coverage.

**Provider Can Only Submit One Claim to PBC at this Time.**

- PBC policy 3B indicates COB with FNHA policy 4000.
- PBC receives EOB from PBC for both Ministry & PBC Coverage.
- PBC forwards claim to FNHA.
- FNHA receives EOB from PBC for both Ministry & FNHA Coverage.

**Member Submits ONE Claim to PBC**

- PBC policy 3B indicates COB with FNHA policy 4000.
- PBC receives EOB from PBC for both Ministry & PBC Coverage.
- PBC forwards claim to FNHA.
- FNHA receives EOB from PBC for both Ministry & FNHA Coverage.

**Provider Submits One Claim to PBC with Primary Policy & 3B and CoB with FNHA Policy & 3B**

- Provider submits One Claim to PBC using MSEP form.
- PBC policy 3B indicates COB with FNHA policy 4000.
- PBC receives EOB from PBC for both Ministry & PBC Coverage.
- PBC forwards claim to FNHA.
- FNHA receives EOB from PBC for both Ministry & FNHA Coverage.

**Claim will Process both PBC & FNHA Coverage**

- FNHA receives EOB from PBC for both Ministry & FNHA Coverage.
- FNHA forwards claim to Ministry.
- Ministry receives EOB from FNHA for both Ministry & FNHA Coverage.

**Provider Submits Claim to PBC using MSEP form.**

- PBC policy 3B indicates COB with FNHA policy 4000.
- PBC receives EOB from PBC for both Ministry & PBC Coverage.
- PBC forwards claim to FNHA.
- FNHA receives EOB from PBC for both Ministry & FNHA Coverage.

**Member Submits ONE Claim to PBC**

- PBC policy 3B indicates COB with FNHA policy 4000.
- PBC receives EOB from PBC for both Ministry & PBC Coverage.
- PBC forwards claim to FNHA.
- FNHA receives EOB from PBC for both Ministry & FNHA Coverage.

**Claim will Process both PBC & FNHA Coverage**

- FNHA receives EOB from PBC for both Ministry & FNHA Coverage.
- FNHA forwards claim to Ministry.
- Ministry receives EOB from FNHA for both Ministry & FNHA Coverage.

**Provider Can Only Submit Assignment of Payment at this Time.**

- Provider submits One Claim to PBC with Primary Policy & 3B and CoB with FNHA Policy & 3B.
- PBC policy 3B indicates COB with FNHA policy 4000.
- PBC receives EOB from PBC for both Ministry & PBC Coverage.
- PBC forwards claim to FNHA.
- FNHA receives EOB from PBC for both Ministry & FNHA Coverage.

**Claim will Process both PBC & FNHA Coverage**

- FNHA receives EOB from PBC for both Ministry & FNHA Coverage.
- FNHA forwards claim to Ministry.
- Ministry receives EOB from FNHA for both Ministry & FNHA Coverage.
9.4 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.

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

9.6 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.

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

10.1 Overview

Pacific Blue Cross will issue a statement to the Provider outlining claim payment details. If you have registered for PROVIDERnet you can access your claim statements through your account. If you do not have PROVIDERnet you will receive paper claim statements. Both the PDF available in PROVIDERnet and the paper statement display the same information.

The details of the statements are outlined below:

1. Provider name and address – This is your mailing address.
2. Date – The date the statement was produced.
3. Your ID Number – Your Pacific Blue Cross Provider ID.
4. Page number
5. Cheque number/Direct Deposit Number – The payment number that appears on a physical cheque attached to the statement or on the Electronic Funds Transfer (EFT) statement.

Health Claim Summary

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

Details

9. Claim ID - The number assigned to each transaction.
10. Purchase Date - The date shown is the exact date the items were purchased.
11. Qty – The quantity.
12. Product or Service - The description of the product or service.
13. Claimed amount - The total cost of the service.
14. Eligible Amount - The amount that is eligible under the plan.
15. Deductible amount - The amount applied to the plan's deductible (if applicable).
16. Co-payment amount - The portion the Member pays out of pocket.
17. Percent covered – The plan percentages vary based on plan design.
18. Plan Paid Amount – The amount the plan pays.
19. Message Code – The explanation of claim payment or reason for refusal.
20. Policy number – This identifies the Pacific Blue Cross plan.
21. ID number – This identifies each Pacific Blue Cross Member.
22. Customer name
10.2 Sample Statement

Health Claim Summary

Total claimed amount $87.50
Amount paid by PBC plan $37.50
Total payment amount $87.50

Details

<table>
<thead>
<tr>
<th>Claim ID</th>
<th>Service Date</th>
<th>Qty</th>
<th>Product or Service</th>
<th>Claimed Amount</th>
<th>Eligible Amount</th>
<th>Deductible Amount</th>
<th>Co-payment Amount</th>
<th>Percent covered</th>
<th>Plan Paid Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>000099999</td>
<td>Mar 20, 2015</td>
<td>1.0</td>
<td>HEARING AID</td>
<td>2000.00</td>
<td>2000.00</td>
<td>0.00</td>
<td>0.00</td>
<td>100%</td>
<td>2000.00</td>
</tr>
</tbody>
</table>

Total for Patient 2000.00 2000.00

PLEASE RETAIN FOR TAX PURPOSES

Health claims questions?
call 604 419-2782
toll-free 1 800 667-8801
or visit us online
www.pac.bluecross.ca
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>
<tr>
<td></td>
<td>• ID or Discharge Certificate from External Affairs Canada or Canadian Armed Forces</td>
</tr>
<tr>
<td></td>
<td>• Consular ID card</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

12.1.1 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.

12.1.2 Terms and Conditions for Submitting Claims Online
When Providers submit claims on PROVIDERnet they also accept and comply to the PROVIDERnet Terms and Conditions for Submitting Claims Online. These Terms and Conditions are found behind the PROVIDERnet log-in screen.

12.1.3 PROVIDERnet – Member Consent and Declaration
At point of claims submission through PROVIDERnet, each provider must click that that they confirm all information in the claim is correct and that they have read and agreed to the Member Consent and Declaration.

I, the Provider, certify that the information contained in this and other documents supporting this claim is complete and true to the best of my knowledge.

I confirm that the expenses submitted on this claim have been provided to the Member.

I acknowledge that I have received a valid and signed Pay Provider Authorization Form from the named Member and I am authorized to receive payment from Pacific Blue Cross for this claim.

I acknowledge that I have the consent of the named Member to release their personal information to Pacific Blue Cross for the purpose of paying this claim and/or confirming the accuracy of the information.

I understand that the billed amounts listed in this claim may not be covered by or may exceed the Member’s plan benefits, and that payment of the uninsured portion is the Member’s responsibility.

I understand and acknowledge that Pacific Blue Cross has the right to conduct audits of claims submitted on behalf of my customers/Pacific Blue Cross Members and if the audit finds evidence of overpayment then Pacific Blue Cross may recover monies previously paid.

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
The Provider must bill the actual product or service being provided. If a discount is given to the Member, bill the actual discounted amount. 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. 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.

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 toll-free 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 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 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.

12.4 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.
12.5 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.

12.6 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.

12.7 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.

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

12.9 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.

12.10 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.

If the ownership of a Provider location is transferred to a new owner, this transfer date will mark the end of the pay-Provider relationship previously established with Pacific Blue Cross. The Provider must inform Pacific Blue Cross in writing prior to the change of ownership and the new owner must apply to enter a new pay-Provider relationship with Pacific Blue Cross.

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 has process controls in place to ensure that claims submitted are appropriate and compliant with any contractual obligations and Terms and Conditions. In addition, Pacific Blue Cross employs a comprehensive audit approach to gain further assurance that claims submitted by Providers are accurate and valid.

All claims submitted to Pacific Blue Cross may be subject to audit by our Audit, Investigations and Quality Assurance Department. Audits are performed to ensure claims, and other eligible benefits and services paid by Pacific Blue Cross are in compliance with the applicable benefit contracts, Terms and Conditions, and the Pacific Blue Cross Hearing Reference Guide.

It is important to note that successful adjudication of a claim does not prohibit Pacific Blue Cross from auditing the claim or the Provider that submitted the claim. If during an audit it is found that inappropriate records, documentation, or procedures were used to support the submission of a claim, which resulted in successful adjudication, Pacific Blue Cross retains the right to recover payments previously made.

13.2 Audit Performance
Audits are performed by the Pacific Blue Cross Audit, Investigations and Quality Assurance Department.

Pacific Blue Cross auditors are staff or agents of Pacific Blue Cross and are authorized to conduct audits for the organization.

Pacific Blue Cross auditors (or agents):
- Perform the Provider audit and prepare the Result Letter.
- Investigate tips and complaints from other Providers, Members, plan sponsors, former employees and the general public.
- Make quality assurance recommendations to Pacific Blue Cross Management based upon audit outcomes.

Audits may be conducted on-site at the Store or via a desk audit, or a combination thereof.

An audit may employ different evidence gathering methods such as, but not limited to, telephone or in-person staff/agent interviews, written correspondence, and Member/Provider verification letters.

13.3 Audit Selection
Selection of a Provider for audit may be made by random selection, payment analytics and comparison of claims data, tips received through the Pacific Blue Cross Whistleblower hotline, complaint or other means.

13.4 Audit Notification
A Provider will be notified of the audit by means of a formal letter.

If the Provider is selected for an onsite audit, Pacific Blue Cross will contact the Provider in advance of the date and time for the onsite audit to provide reasonable notice to accommodate the needs of the Provider, unless Pacific Blue Cross has reasonable grounds to believe that the Provider would not cooperate with the auditors if given such notice.

Notification of a desk audit does not preclude Pacific Blue Cross from initiating an on-site audit if the record and documentation review supports a more in-depth audit.
13.5 Auditor Access
If a Store is selected for an onsite audit, the Store owners or directors will ensure that all store staff and its agents will co-operate with the audit. This includes:
- Providing Pacific Blue Cross Auditor(s) or agents access to the site, and
- Granting access to the original required records for review, copying and scanning.

13.6 Confidentiality
All records and documentation used for the audit shall be kept confidential. All personal information shall not be disclosed to any person, unless required by law or authorized in accordance with applicable privacy legislation.

13.7 Auditable Records
During a Store audit, Pacific Blue Cross will audit all Provider records and documentation relevant to the identified claims submissions, billing and payment for services and supplies provided to Members of Pacific Blue Cross.

The Store must retain and make available all relevant original records and documentation that support the claims submission and make the records and documentation available for Pacific Blue Cross’ audit. The records that may be audited include, but are not limited to:
- Manufacturer, distributor, and wholesaler invoices;
- Prescription records and associated documentation;
- Relevant inventory management records;
- Patient charts and appointment records; and
- Any other record that is relevant to Claims submissions, billings and payments.

If a Store is selected for a desk audit, a request will be made by formal letter for copies of relevant records. The store has thirty (30) days, or a longer time as agreed by the parties, to provide the requested records.

If a Store is selected for an on-site audit, Pacific Blue Cross Auditors or agents will make copies of the relevant records at the time of the on-site audit. Any records outstanding at the conclusion of the on-site audit will be noted and the store will be provided fourteen (14) days, or a longer time as agreed by the parties, to provide the requested records.

If the time period has passed to produce the records and the requested records have not been produced, Pacific Blue Cross will reasonably conclude that no records exist to support a claim, or the documentation supporting a claim is incomplete or insufficient.

13.8 Disallowed Claims
In the context of an audit, if in the reasonable opinion of Pacific Blue Cross auditors or agents, no records exist to support a claim, or the documentation supporting a claim is incomplete or insufficient, the claim will be disallowed, and any amount associated with the claim will be owing to Pacific Blue Cross.

13.9 Result Letter
A Result Letter will be provided to the Store at the conclusion of the audit.

The Result Letter will identify:
- The results of the audit and the methodologies used to determine the results.
- Any audit recovery due to disallowed claims and the methodology used to calculate the recovery.

The Store has thirty (30) days, or a longer time as agreed by the parties, to respond to the Result Letter by:
- Confirming the results, or
- Requesting reconsideration of the results and providing relevant additional information, documents or materials to support the request. Reconsideration may be requested for the following reasons:
  - identification of recovery calculation errors and/or
identification of information, documents or materials that may have been overlooked

If the Store does not respond within thirty (30) days, or a longer time as agreed by the parties, then Pacific Blue Cross will reasonably conclude that no response is forthcoming, and the Result Letter will stand to identify the conclusion of the audit.

If the Store requests a reconsideration and after PBC reviews the request, Pacific Blue Cross may issue a new Result Letter.

The Result Letter will identify conclusion of the audit with either:

- No further action, or
- Required recovery of funds.

In the event of a recovery of funds, the Result Letter will outline any recovery options, if applicable.
14.0 Appendix 1: First Nations Health Authority - Effective September 16, 2019

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 Aiyansh)
   • Lakalzap #678 (Greenville)
   • Gitwinksilkw #679 (Canyon City)
2) Inuit
3) Mohawks of Akwesasne #159
4) Bigstone Cree #458

14.5 Claiming Procedures
14.5.1 Overview
Claims can be submitted to Pacific Blue Cross on behalf of FNHA clients through PROVIDERnet or by paper.

If you are submitting a claim through PROVIDERnet, all the provisions previously outlined in this guide continue to apply.

Note: To submit a claim for an FNHA client in PROVIDERnet, enter 40000 in the policy field and enter their Status Number in the ID/Status Number field.

There is a unique paper claim form and process for FNHA clients that is outlined below.

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

14.5.3 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 fax (for FNHA clients only: 604.677.0277). Incomplete forms will be rejected and must be resubmitted.
Begin by downloading and printing out the **FNHA – Health Claim/Pre-determination Form** from our website.

- At the top of the form, select “pre-determination.”
- Fill in sections 1 – 4 of the Claim Form (signatures are not required on a pre-determination) and print it.
  - If you are filling it in by hand, please use blue or black ink only.
- Enclose copies of all supporting medical documentation (if required).

Pre-determinations mailed to Pacific Blue Cross will be responded to by mail. A copy of the pre-determination will be sent the client on 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.

### 14.5.4 Submitting a Claim

For detailed information about submitting claims through PROVIDERnet please see [Section 8.3.6](#).

To submit a paper claim on behalf of an FNHA client, begin by downloading and printing out the **FNHA – Health Claim/Pre-determination Form** from our website.

- At the top of the page, select “Claim.”
- Fill in all sections of the Claim Form and print it.
  - If you are filling it in by hand, please use blue or black ink only.
- Include a full quote for the product or service
- Ensure all supporting medical documents are included

**Note:** Please ensure that both the client and Provider have signed the form. Incomplete forms will be rejected and must be resubmitted.
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 achieve their social and economic potential. Pacific Blue Cross administers hearing and vision claims on their behalf.

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

15.2 Overview
The sections that follow outline only where procedures for assisting an MSDPR client differ from those outlined elsewhere in this reference guide.

15.3 Client Identification
As outlined in Identifying Blue Cross Members, MSDPR clients will have a either a BC 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 Claiming Procedures
15.4.1 Overview
To submit claims on behalf of an MSDPR client, there are specific rules and guidelines that must be followed.

15.4.2 Check Member Eligibility
To assist a client, follow these four easy steps:

1) Call Pacific Blue Cross to confirm client eligibility.
2) Submit a pre-determination.
3) If approved, provide the service/product to the MSDPR client.
4) Submit claim for payment with Policy 13139 and the Personal Health Number (PHN).

This includes eligible items such as hearing aids, bone anchored hearing aids, cochlear implants, new requests, repairs, batteries, supplies, and replacements.

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

15.4.3 Check Claiming Requirements
Pacific Blue Cross will limit payment according to the plan provisions:
- Hearing instruments are paid up to $2,000.00 per ear.
- New Hearing instrument purchases must include:
  - Free assessment & 60-day trial of hearing instruments;
  - 1-year supply of batteries (included in the purchase cost); and
  - 1-time replacement coverage (paid at $300 per aid at the time of occurrence).
- Hearing instruments are eligible for replacement after 3 years from the purchase date.
15.4.4 Submitting Supporting Documentation
Pacific Blue Cross will accept pre-determinations submitted on the MSDPR Hearing Instrument Form.

To ensure prompt and accurate processing, you must accurately identify the client. The pre-determination will be rejected if information is incorrect or missing from the form.

When submitting a pre-determination, remember:
- Each submission must show your Pacific Blue Cross Provider Number.
- The date of service is not required.
- Only the Provider signature is required.
- Do not obtain client signatures on blank or incomplete forms.
- The Provider remains solely responsible for all pre-determinations/quotes submitted.

Mail MSDPR pre-determinations to:

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

15.4.5 Submitting a Claim
Pacific Blue Cross will accept claims submitted on the MSDPR Hearing Instrument Form.

If the claim form has been completed in full, an invoice is not required. Incomplete claim forms will be rejected and returned to the sender.

Claims are processed on a “first come, first served” basis, therefore timely submission is encouraged.

The Provider will mail claims directly to Pacific Blue Cross; however, Pacific Blue Cross will not accept liability for claims received later than the claiming deadline of one year from the date of service. No payment will be made on any claim received later than one year from the date of service.

The Provider must bill the actual product or service provided and the total amount (less any client discounts). Payment of the uninsured portion is the client’s responsibility. Claims will only be coordinated at Pacific Blue Cross provided the client is covered by another Pacific Blue Cross plan and the Provider submits a completed Pay Provider Member Consent form from the Pacific Blue Cross Member. The MSDPR plan is payor of last resort.

The Provider agrees not to bill the client until payment has been received from Pacific Blue Cross.

When submitting a claim form, remember:
- Each submission must show your Pacific Blue Cross Provider Number. Failure to do so will result in delayed payment.
- The date of service is the date the item/service was provided to the client.
- The client and Provider must both sign the claim form.
- Do not obtain client signatures on blank or incomplete forms.
- The Provider remains solely responsible for all claims submitted.

Mail MSDPR Claims to:

Pacific Blue Cross
PO Box 65339
Vancouver, BC V5N 5P3
15.4.6 Payment Schedule
Pacific Blue Cross will reimburse the Provider for claims submitted for payment on a weekly basis via paper cheque. If you have signed up for direct deposit on PROVIDERnet to assist other Members, you will receive direct deposit.

Pacific Blue Cross will issue a statement to the Provider outlining claim payment details. Refer to the Pacific Blue Cross Statements section of this guide for more details.

15.5 Overpayment
Overpayments may include claims with incorrect payment, inappropriate billing, or misrepresentation of services rendered.

If you do not have direct deposit set up and an overpayment or error occurs, cash the original cheque from Pacific Blue Cross. You can either call Customer Services or mail the information to Pacific Blue Cross to request an adjustment. Pacific Blue Cross will review the appropriate claim(s) and the adjustment(s) will show on the next statement(s).

15.6 Audit of Records/Files
To ensure compliance with legal obligations with clients, Pacific Blue Cross reserves the right to request copies of any records, such as the client’s treatment files or financial records, in the possession of the Provider, which are relevant to any claim being audited by Pacific Blue Cross.

Pacific Blue Cross will present a signed authorization from the client for consent to the disclosure of personal information at the time of the request for the records and information pertaining to a claim.

Where an audit indicates a payment error, the error will be corrected, and proper payment will be made to Pacific Blue Cross or to the Provider, as applicable.

Pacific Blue Cross shall maintain the confidentiality of these records in accordance with applicable privacy laws.
# 16.0 Appendix 3: 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 with Personal Health Number</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 Personal Health Number</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>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 the provision of Hearing services to 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 of Benefits (COB)</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>Co-payment</td>
<td>A portion of an insured’s 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>
<tr>
<td>Term</td>
<td>Definition</td>
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<td>------------------------------------------</td>
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</tr>
<tr>
<td>Dependent</td>
<td>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.</td>
</tr>
<tr>
<td>Electronic Funds Transfer (EFT)</td>
<td>Electronic funds transfer is an electronic delivery of claim payments, directly deposited into the Provider’s designated bank account on the day the payment is issued.</td>
</tr>
<tr>
<td>Explanation of Benefits (EOB)</td>
<td>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.</td>
</tr>
<tr>
<td>Government plan</td>
<td>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.</td>
</tr>
<tr>
<td>Member</td>
<td>The person, having coverage who has a direct relationship with the Contract holder or the Participating Employer.</td>
</tr>
<tr>
<td>British Columbia Personal Health Number (PHN)</td>
<td>A unique lifetime identifier for health care in British Columbia. PHN remains the same, regardless of any changes to a resident's personal status.</td>
</tr>
<tr>
<td>Personal Information</td>
<td>Means any information about an identifiable individual.</td>
</tr>
<tr>
<td>Practitioner</td>
<td>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.</td>
</tr>
<tr>
<td>Prescription</td>
<td>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</td>
</tr>
<tr>
<td>Primary Administrator</td>
<td>In PROVIDERnet, this is a person who has access to add/edit banking information and who also has access to submit an electronic claim.</td>
</tr>
<tr>
<td>Provider</td>
<td>Means a person, group, or other entity currently licensed, certified, or registered to provide an eligible service, medical...</td>
</tr>
</tbody>
</table>

16.0 Appendix 3: Glossary
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.

<table>
<thead>
<tr>
<th>Provider Number</th>
<th>A unique reference number assigned to the Provider as identification to facilitate the submission of claims for adjudication and to receive payment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Qualified Staff</td>
<td>Staff who are qualified for the given purpose and have complied with specific requirements.</td>
</tr>
<tr>
<td>Spouse</td>
<td>Means: a) the person legally married to the Member, or b) a Member’s spouse, as that term is defined within the appropriate provincial, federal, or territorial legislation, as amended from time to time. Only one Spouse is eligible for coverage at any one time.</td>
</tr>
<tr>
<td>Standard Administrator</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>Store</td>
<td>A business that sells products to the public for use or consumption rather than for resale.</td>
</tr>
</tbody>
</table>