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1.0 Introduction

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

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

Icons

Icons have been added throughout the 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 1.5 million British Columbians through employee group plans and through individual plans for those who do not have coverage with their employer. Pacific Blue Cross and BC Life continue to respond to customers’ needs in plan design, administration and technology.

Contact Us

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

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

3.1 Plans

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

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

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

3. **Government-Funded Plans**: These are plans for individuals in British Columbia and the Yukon that are funded by a government program.
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 National Blue Cross Identification Cards
A Member’s National Blue Cross card is double-sided and plastic, similar to bank cards but without raised lettering. The design of these cards is consistent across all regions. Customers have the option of an English or French card, based on the Member’s preference.

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

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

5.1 Overview
Becoming a Pacific Blue Cross Provider allows you to submit claims to Pacific Blue Cross on behalf of your 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.

5.2 Pacific Blue Cross Health Provider Requirements
Pacific Blue Cross registers the Provider and issues a Pacific Blue Cross Provider number. To register as a Provider, you must have at least one of the following practitioners in your office:

- Acupuncturist
- Chiropractor
- Massage Therapist
- Naturopathic Doctor
- Physiotherapist
- Podiatrist
- Psychologist

To receive standing as a Health Provider, you must provide the college registration number of all registered staff.

5.3 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 duly registered 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 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.
5.4 How to Register as a Pacific Blue Cross Health 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 so that there are no delays.

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

- Name and contact information of the corporate contact.
- Name and college registration number of all practitioners.

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

- FAQs
- 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 office. Each location of a chain 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 6.3.
- If your application is denied, you will be emailed the reason and may re-apply (if applicable).

5.5 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, or by licensed healthcare professionals, duly registered staff, qualified employees, subcontractors, or independent contractors, working at their office, 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

**Corporate Contact:** A person who has access to add/edit banking information and who also has access to submit an electronic claim through PROVIDERnet. This person can also view claim details and statements for more than one practitioner if applicable.

Examples:

- Multi-disciplinary Clinic: Office Manager, Owner, Front Desk (if applicable)
- Individual Practitioner Clinic: Practitioner

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

Examples: ABC Massage on 1st Street; 123 Physiotherapy on 2nd Avenue
**Practitioner:** The individual providing the service.

Examples: Dr John Smith DC; Jane Wilson RMT; Dr S Jones ND

**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:
- Multi-disciplinary Clinic: Practitioner
- Individual Practitioner Clinic: Front Desk (if the practitioner wishes to not allow them access to update banking information).

**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.
5.6 Understanding PROVIDERnet Account Types

5.6.1 Overview
PROVIDERnet accounts can vary depending on how your office is structured. The following infographics will help you understand how you register with Pacific Blue Cross.

5.6.2 Which Scenario Are You?

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**Decision Tree**

How many Practitioners are in your office?

- **ONE PRACTITIONER**
  - Scenario 1

- **MULTIPLE PRACTITIONERS**
  - How many bank accounts?
    - **Scenario 2**
      - One bank account for the entire office
    - **Scenario 3**
      - One bank account for each Practitioner
5.6.3 Individual Practitioner
5.6.4 Multi-Disciplinary Clinic – One Bank Account

Scenario 2

- PRIMARY ADMINISTRATOR(S)
  - Statement Access
  - Preferred Email
  - Submit eClaim
  - Adds Banking Information

- PROVIDER OFFICE
  - Provider ID #
  - Bank Account

- PRACTITIONER A
- PRACTITIONER B
- PRACTITIONER C

*Email for each Practitioner*
*Each Practitioner may submit eClaims*
5.6.5 Multi-Disciplinary Clinic – Multiple Bank Accounts

**Scenario 3**

- PRIMARY ADMINISTRATOR(S)
  - Statement Access
  - Preferred Email
  - Submit eClaim
  - Adds Banking Information

- PROVIDER OFFICE
  - Provider ID # for each Practitioner
  - Bank Account for each Practitioner

- ARROW POINTING UP TO:
  - PRACTITIONER A
  - PRACTITIONER B
  - PRACTITIONER C

  - Email for each Practitioner
  - Each Practitioner may submit eClaims
6.0 About PROVIDERnet

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

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

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

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

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

To activate your web account, click on the activation code in your email.

Activate your PROVIDERnet account
A Pacific Blue Cross PROVIDERnet account has been created for you.
Click on the activation code below to activate your account.

uYEGkdZm

With this service, you can:
1. Submit electronic claims for Pacific Blue Cross members
2. Add banking information
3. Access resources
4. And much more
Enter in your Provider ID and the Account Activation Code you received in your email.

Create your password and challenge questions.

Read the User Agreement and Privacy Policy, then click the I accept the User Agreement and Privacy Policy checkbox.

You have successfully created your account and will be sent a confirmation email.
6.4 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.

6.5 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 and click Make UPDATES to your account for the following:
- Closing a Provider Location
- Change of Address
- Change of Location Name
- Add/Remove Practitioner

6.6 Forgot Your Password?
If you have forgotten your password to log in to PROVIDERnet, go to the login page and select Forgot your password?
Enter your Provider ID Number and email address, then click *Continue*.

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

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

**Note:** *This temporary password is only active for 24 hours.*
7.0 Claiming Procedures

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

The Provider will submit claims in accordance with the criteria in this Pacific Blue Cross Reference Guide.

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

7.2 PROVIDERnet Claiming

7.2.1 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.

7.2.2 Check Member Eligibility
The easiest way to assess Member eligibility is to submit and reverse a claim in PROVIDERnet.

To learn about submitting a claim through PROVIDERnet, see Section 7.3.6, and to learn about reversing a claim in PROVIDERnet, see Section 7.3.9.

Member eligibility can also be confirmed by calling Pacific Blue Cross at 604-419-2000 or toll-free at 1-877-PAC-BLUE.

7.2.3 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.

7.2.5 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.
7.2.6 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:
Visit providernet.ca and 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 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 and 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 8.0)
- 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.
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.

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 7.3.9).

You can also check back to see when the claim’s pend status is resolved and bill the member the remaining balance if applicable.
7.3.7 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.

7.3.8 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
**View Details**
You can view the details of an Expense/Item by clicking on the Details button.

Reviewing the Claim Details section below 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.

---

**7.3.9 Reverse a Claim**
If you need to reverse a claim, you must be in the claim history screen. (Follow the steps outlined in Section 7.3.8 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
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.
7.3.10 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.

7.3.11 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).
8.0 Coordination of Benefits (COB)

8.1 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.
8.2 Coverage with Another Insurance Carrier
For customers whose additional coverage is with another health benefits carrier, continue to submit two claims with the pertinent plan information with each claim to each benefits carrier. The amount paid by the primary plan is always required along with your claim form when submitting a COB claim where Pacific Blue Cross is the secondary plan. Claims submitted without a statement from the primary carrier indicating the amount paid for each line item will be rejected until this documentation is provided.

8.3 Dual Pacific Blue Cross Coverage
For Members with more than one Pacific Blue Cross plan, or whose additional coverage is with a national Blue Cross plan, submit only one claim. For electronic claims, when there are two Pacific Blue Cross plans, they will be coordinated automatically.

8.4 Provide all COB Information
To prevent the delay of assessment please provide any pertinent information that will assist Pacific Blue Cross in determining the order of payment. It is a requirement to retain proof of payment (copy of the Explanation of Benefits) when another carrier is involved. This assists with the processing of a claim when deductibles or limitations are reached under the primary plan. If the primary plan is no longer in effect, please contact Pacific Blue Cross to provide the termination date.

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

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

8.7 Some Plans are Always Secondary
Some plans always pay last.
Effective July 2019

9.0 Pacific Blue Cross Claim Statements

9.1 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.

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.
### 9.2 Sample Statement

**Direct Deposit Statement**

Jun 14, 2019  
Your ID Number: 1234567890  
Direct Deposit Number: 1234

***Payment may take up to 3 business days to be deposited to your account***

#### Health Claim Summary

<table>
<thead>
<tr>
<th>Total claimed amount</th>
<th>$93.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount paid by PBC plan</td>
<td>$90.00</td>
</tr>
<tr>
<td>Total payment amount</td>
<td>$90.00</td>
</tr>
</tbody>
</table>

#### Claim Statement questions?

Call 604 419-2000  
Toll-free 1 877 PAC-BLUE  
Visit us online pac.bluecross.ca

---

#### Details

<table>
<thead>
<tr>
<th>Claim ID</th>
<th>Policy Number: 99999</th>
<th>ID Number: 1234567</th>
<th>Patient Name: Jane Doe</th>
</tr>
</thead>
<tbody>
<tr>
<td>00000000</td>
<td>Jun 11, 2019</td>
<td>1.0 Massage Sub 45 min</td>
<td>93.00</td>
</tr>
</tbody>
</table>

Total for Patient  
93.00  
90.00  

05214 - Payment has been reduced as the maximum amount paid for this benefit has been reached.
10.0 Fraud Prevention
We want to encourage Providers to learn how to recognize and report fraud in order to help stop it.

10.1 Help Prevent Identity Fraud

*Prior to accepting coverage and completing a sale for a new Member, 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>

10.2 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.
11.0 Provider Guidelines

11.1 PROVIDERnet

11.1.1 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.

11.1.2 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.

11.1.3 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.

11.2 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.

11.2.1 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.

11.2.2 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.
11.2.3 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.

11.2.4 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).

11.2.5 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.

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

11.2.7 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 Pacific Blue Cross 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.

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

11.3 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.

11.4 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.

11.5 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.
11.6 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.

11.7 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.

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

11.9 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.

11.10 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 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.
12.0 Audit

12.1 Background
Pacific Blue Cross has process controls in place to ensure that claims submitted are appropriate and compliant with any contractual obligations. 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 Pacific Blue Cross Health 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.

12.2 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 Provider’s office 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/practitioner verification letters.

12.3 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.

12.4 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.
12.5 Auditor Access
If a retailer is selected for an onsite audit, the office owners or directors will ensure that all office staff and its agents will co-operate with the audit. This includes:
- Providing Pacific Blue Cross Auditor(s) or agents access to the office, and
- Granting access to the original required records for review, copying and scanning.

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

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

The office must retain and make available all relevant original records and documentation that support the claims submission and make the records and documentation available for audit. The records that may be audited are:
- 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 an office is selected for a desk audit, a request will be made by formal letter for copies of relevant records. The office has thirty (30) days, or a longer time as agreed by the parties, to provide the requested records.

If an office 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 office 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.

12.8 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.

12.9 Result Letter
A Result Letter will be provided to the office 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 office 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 office 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 office requests a reconsideration and after PBC reviews the request, Pacific Blue Cross will 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 the recovery options.
## 13.0 Appendix 1: 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>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 health services to Clients in accordance with the Agreement, Reference Guide, and policies of the Program.</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>Corporate Contact</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>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>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>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>----------------------</td>
<td>-------------------------------------------------------------------------------------------------------------------------------------------</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>Office</td>
<td>A business location that used to provide a particular service to the public.</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>Provider</td>
<td>Means a person, group, or other entity currently licensed, certified, or registered to provide an eligible service, medical supply, or equipment by the appropriate licensing, certification, or registration authority in the jurisdiction where the services or equipment are provided or, where no such authority exists, has a certificate of competency from the professional body which establishes standards of competence and conduct for the profession, and is acting within the scope of that license. We reserve the right to refuse the service, medical supply or equipment from the Provider based on ineligibility or based on the Provider’s qualifications or conduct.</td>
</tr>
<tr>
<td>Provider Number</td>
<td>A unique reference number assigned to the Provider as identification to facilitate the submission of claims for adjudication and to receive payment.</td>
</tr>
<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>
</tbody>
</table>
Phone 604 419-2000
Toll-free 1 877 PAC-BLUE
Website pac.bluecross.ca

Mailing Address
PO Box 7000
Vancouver, BC V6B 4E1

Street Address
4250 Canada Way
Burnaby, BC