PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | Fax: 604 419-2689 | Toll-free fax: 1 844 419-2689 | pac.bluecross.ca

⊘ PLEASE DO NOT STAPLE

HOW TO COMPLETE THIS FORM:
PLAN MEMBERS — Please complete RED portions of this form.
PHYSICIANS — Please complete PART 2 of this form.
PROVIDERS — Please complete PART 3 of this form

Don't forget to sign *Part 4 — Member Consent and Declaration* before you submit your claim.

The patient is responsible for any fees charged by the physician for completion of this form. These fees are not eligible for reimbursement under your Pacific Blue Cross Extended Health Care plan.

Completion of this form does NOT imply approval for a Sleep Apnea device or supplies. Coverage is based on the provisions of your Extended Health Care plan and Pacific Blue Cross qualification criteria.

PART 1 — PLAN MEMBER TO COMPLETE

Plan member's name	Patient's name (if different than Plan member's name)

Patient's birthdate (mm-dd-yyyy)	Patient's weight	Patient's height	Policy number	ID number	☐ Other insurance coverage

Street address	City	Province	Postal code	Daytime phone number (10 digits)

PART 2 — MEDICAL INFORMATION: TO BE COMPLETED BY PHYSICIAN

Prescribing physician: ☐ GP ☐ Specialist type: ______________________ Physician's name: ______________________

Diagnosis: ______________________

Does the patient have any co-morbidities or any other medical conditions that should be disclosed for our eligibility review?:

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Type of device prescribed: ______________________

1. Is this the first sleep apnea device the member has used? ☐ Yes ☐ No — If no, provide the type of device and how long your patient has used it:

   ____

2. If the patient is switching from one device to another e.g. from CPAP to Mandibular Advancement Device or other PAP device or vice versa, please provide the medical reason:

   ____

   ____

   ____

I certify that I am the primary physician in the management of the patient's sleep apnea disorder and that I have consulted with the patient in person. If you have not consulted with the patient in person, please provide an explanation.

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Physician's signature X	Date (mm-dd-yyyy)

PART 3 — REPORTS: TO BE COMPLETED BY PROVIDER

Provide a copy of the Sleep Study report (AHI must show on this report).

- AHI: ______________________

☐ For PAP Devices, i.e., CPAP: I confirm I will provide the Pacific Blue Cross member a 30 day trial period and I will keep the compliance report on file for 5 years. I confirm that if Pacific Blue Cross requests this report that it will be provided to them, when requested.

Name	Company name	Phone number (10 digits)

Provider's signature X	Date (mm-dd-yyyy)

Place your receipts loose and flat in the envelope — no staples, paperclips or tape. Also no cashier or Interac receipts.

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PART 4 — MEMBER CONSENT AND DECLARATION

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

I declare that all information in this form is true and complete. I understand Pacific Blue Cross will use the personal information on this form, and any other personal information they hold about me and my eligible dependents to determine eligibility for benefits and pay claims.

I acknowledge and agree that personal information about me and my eligible dependents may be collected, used and exchanged between Pacific Blue Cross and any other person or organization related to this claim or the administration of my benefit plan. This includes health care professionals, institutions, investigative agencies, insurers/re-insurers, government organizations or regulatory bodies. I acknowledge disclosure of my personal information by Pacific Blue Cross to my plan sponsor when required or permitted by law or pursuant to its contractual obligations under my benefit plan. I understand I may revoke this consent at any time and acknowledge that should I do so, this claim may not be considered.

If there is overpayment, I authorize its recovery from any amount payable to me under my benefit plan(s).

I have read and understand this Member Consent and Declaration and agree that a photocopy or digital version shall be as valid as the original and may remain in effect for the continued administration of this plan. I authorize my physician to release my personal information to Pacific Blue Cross to obtain approval for prescription benefit.

Member's signature X	Date (mm-dd-yyyy)

MAIL YOUR FORM
Pacific Blue Cross
PO Box 7000, Vancouver, BC V6B 4E1

DROP IT OFF
4250 Canada Way
Burnaby, BC V5G 4W6

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Toll-free: 1 844 419-2689

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