PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

STUDENTCARE

LSU HEALTH CLAIM FORM

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | pac.bluecross.ca

Use this form to submit a claim for all medical expenses and services. Please enclose all supporting documentation, original receipts and complete all parts of this form to avoid delays in processing your claim. **For information, visit studentcare.ca or call 1 866 369-8796.**

PART 1 — STUDENT INFORMATION

Policy number	Student ID number (9 digits)	Name of plan, company name or Plan sponsor (if applicable)
2953		LSU Health Plan

First name	Last name	Daytime phone number (10 digits)

Street address	City	Province	Postal code	New address?
				☐ Yes

PART 2 — OTHER INSURANCE COVERAGE

Complete this section if you or your spouse are covered under another plan. Please see the special instructions for coordination of benefits on page 2.

Other insurance coverage ☐ Pacific Blue Cross ☐ Other insurer: _____	Coverage start date (mm-dd-yyyy)

Member's policy number	Member's ID number	Plan member ☐ Same as above ☐ Spouse	Cancellation date if applicable (mm-dd-yyyy)

Spouse's first name if spouse's plan	Spouse's last name if spouse's plan	Employment status of spouse ☐ Full-time ☐ Part-time ☐ Retiree ☐ Student	Spouse's birthdate (mm-dd-yyyy)

PART 3 — INFORMATION ABOUT YOUR CLAIM

Please provide the first name and birthdate of all eligible dependents with a claim.

For each dependent, add up all receipts and provide the total amount of their expenses.

FIRST NAME	BIRTHDATE	TOTAL EXPENSES
	(mm-dd-yyyy)	$
	(mm-dd-yyyy)	$
	(mm-dd-yyyy)	$
	(mm-dd-yyyy)	$
	GRAND TOTAL	$ 0

Remember to enclose all supporting documentation and original receipts. You can mail your claim to us or drop it off at our Burnaby office.

1. Are the expenses you're claiming:
   - The result of a workplace injury? (i.e., WorkSafeBC) ☐ Yes ☐ No
   - The result of a motor vehicle or other accident? ☐ Yes ☐ No
   - Are you seeking damages from a 3rd party? ☐ Auto ☐ WorkSafeBC ☐ Other: _____

   (If yes to any of the above, please complete an *Accident or Injury Reimbursement Agreement Form* available on Member Profile.)

2. Have any of your expenses been paid by another insurance company? (If yes, include photocopies of your receipts and the claim statement provided by the other insurance company.) ☐ Yes ☐ No

PART 4 — STUDENT CONSENT AND DECLARATION

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

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 Student 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.

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

TIPS FOR PREPARING YOUR CLAIM

1. All claims must be submitted with original, paid-in-full receipts which show:
   - Claimant's first and last name
   - Description of item(s) purchased or service(s) rendered
   - Date of each purchase or service
   - Amount charged for each purchase or service
   - Name, address and phone number of supplier or provider
   - Provider registration number (if applicable)
2. Please keep photocopies of your receipts. Pacific Blue Cross does not return original receipts.
3. Place your receipts loose and flat in the envelope — no staples, paperclips or tape.
4. Submit only one of each official receipt. Do not include any cashier or Interac receipts.
5. Not all benefit coverage is the same. Visit studentcare.ca or call Studentcare at 1 866 369-8796 for help completing this form or for more information on your health plan, including your claiming deadline.
6. Don't forget to sign *Part 4 — Student Consent and Declaration* before you submit your claim.

INCOMPLETE FORMS MAY DELAY THE PROCESSING OF YOUR CLAIM.

PACIFIC BLUE CROSS®

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

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

pac.bluecross.ca

SPECIAL INSTRUCTIONS

COORDINATION OF BENEFITS

Only complete *Part 2 — Other Insurance Coverage* if you or your spouse are covered under another plan. Send your claim to your plan first. When you receive your claim statement, send a copy of that statement plus copies of your receipts to your other plan to claim any unpaid amount.

If you have claims for your children, send those claims first to the plan of the parent whose birthday falls earlier in the year.

Learn more about coordination of benefits at pac.bluecross.ca.

WORKPLACE, AUTOMOBILE OR OTHER ACCIDENTS

If your claim is a result of a workplace or automobile accident or an incident where third party liability may be involved, please complete and submit an *Accident or Injury Reimbursement Agreement Form* in addition to this *Standard Health Claim Form*. All forms are available on Member Profile.

ORTHOTICS AND ORTHOPEDIC SHOES

If this benefit is covered by your plan, visit Member Profile to view a list of special claiming criteria and to download an additional form (either the *Custom Foot Orthotics Claiming Checklist* or the *Custom Orthopedic Shoe Claiming Checklist*) which must be submitted with your claim.