PACIFIC BLUE CROSS®

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CLAIM FOR TUITION EXPENSES PHYSICIAN'S STATEMENT

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | www.pac.bluecross.ca

STUDENTS — Please complete RED portions of this application.
PHYSICIANS/DENTISTS — Please complete BLACK portions of this application.

PART 1 — STUDENT INFORMATION

First name	Last name	Sex ☐M ☐F	Birthdate (mm-dd-yyyy)

Street address	City	Province	Postal code

Daytime phone number (10 digits)	Student ID number (printed on your student ID card)	Policy number	Name of plan policyholder

PART 2 — PHYSICIAN OR DENTIST'S STATEMENT

1. Diagnosis (including complications)

1.1 Primary:

1.2 Secondary:

1.3 Findings (please enclose a copy of current x-rays, EKGs, laboratory data, blood pressure and any other relevant clinical findings):

2. Treatment dates

2.1 Date of first visit for current condition (mm-dd-yyyy): _____

2.2 Date of latest visit (mm-dd-yyyy): _____

2.3 Frequency of visits: ☐ Weekly ☐ Monthly
☐ Other (specify): _____

2.4 Date patient's condition first prevented them from attending all classes (mm-dd-yyyy): _____

2.5 Date of in-patient admission (mm-dd-yyyy): _____

2.6 Date of discharge (mm-dd-yyyy): _____

2.7 Date of out-patient treatment (mm-dd-yyyy): _____

2.8 Name of hospital:

3. Nature of treatment

3.1 Medications (dose, frequency, date prescribed):

3.2 Surgeries (including dates):

3.3 Other (including frequency):

3.4 Is patient following recommended treatment program? ☐ Yes ☐ No — Please elaborate: _____

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4. Progress

4.1 Has patient: ☐ Recovered ☐ Improved ☐ Not improved ☐ Retrogressed

4.2 Current status: ☐ Ambulatory ☐ House confined ☐ Bed confined ☐ Hospital confined

5. Restrictions and limitations

5.1 How is your patient limited from attending all classes? What prevents them from returning to college or university?

6. Plans to return to school

6.1 Prognosis for improvement or recovery:

6.2 Date patient expected to be able to return to school (mm-dd-yyyy): _____

6.3 If unknown, please indicate the next follow-up date (mm-dd-yyyy): _____

6.4 Has a return to school been discussed with the patient: ☐ Yes ☐ No

6.5 Please elaborate on time frames and patient's response:

7. Comments

7.1 Is there any other information you wish to add that will give us a better understanding of your patient's condition or treatment requirements?

PART 3 — IDENTIFICATION OF PHYSICIAN

The information in this statement will be kept in a life, health, or disability benefits file with the insurer or plan administrator and might be accessible by the patient or third parties to whom access has been granted or those authorized by law. By providing the information I consent to such unedited release of any information contained herein.

Physician's name (please print)	Certified Specialty	License number

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

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

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

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Burnaby, BC V5G 4W6

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