BRITISH COLUMBIA | Ministry of Health

PHARMACARE PROVIDER ENROLLMENT

HLTH 5432 2021/10/19

Please read the Provider Enrollment Guide prior to completing this form. The Enrollment Guide will help you complete the form correctly and completely. ***Incomplete or inaccurate forms will be returned unprocessed.*** You may wish to consult with your legal counsel while preparing this form and associated documentation.

1. SITE INFORMATION *(all fields in this section are mandatory)*

a. Operating Name		b. Site ID	
c. Site Address *(street location – do not include P.O. Box)*	City	Prov	Postal Code
d. Mailing Address *(if different from Site Address – can be P.O. Box)*	City	Prov	Postal Code
e. Payment Remittance Address *(if different from Site Address – can be P.O. Box)*	City	Prov	Postal Code

Site Phone Number	Site Fax Number	f. Email Address *(site or manager)*
g. Site Manager Name *(First/Last – must match college registration ID)*	Registration ID *(5 digits)*	h. Proposed Opening Date *(TBA not acceptable)*

2. PROVIDER TYPE *(Mandatory – must choose at least one Pharmacy or Device Class)*

a. Pharmacy Class	**b. Pharmacy Sub-class** *(check all that apply)*
☐ Community Pharmacy OR ☐ Out-Patient Hospital Pharmacy	☐ Opioid Agonist Treatment Provider ☐ Plan B Pharmacy
c. Device Class	**d. Device Sub-class** *(check all that apply)*
☐ Devices	☐ Compression Garment Provider ☐ Limb Prosthesis Provider ☐ Breast Prosthesis Provider ☐ Ocular Prosthesis Provider ☐ Orthosis Provider ☐ Insulin Pump Manufacturer / Distributor* ☐ Other* (ostomy supplies, diabetes supplies) **DO NOT check box if you are a community pharmacy.*

Pharmacies: Please include copy of **College of Pharmacists of BC** (CPBC) licence with application.
Non-Pharmacy Device Providers: Please include copy of business licence.

3. SUB-CLASS ELIGIBILITY

Please answer all of the following class-specific questions that apply to your site (as indicated in section 2 above).

IMPORTANT: If you answer **No** to any of the questions below, **attach a written explanation** as to why PharmaCare should consider enrolling you in this sub-class.

1. **Opioid Agonist Treatment**
   Have all the pharmacists providing any services at your pharmacy successfully completed the relevant training for the provision of methadone maintenance services? *(please see Enrollment Guide for training requirements)* ☐ Yes ☐ No
2. **Compression Garment**
   Are compression garments being fitted only by persons who have completed training by a manufacturer of compression garments in fitting the type of compression garment being fitted? ☐ Yes ☐ No
3. **Limb Prosthesis**
   Are limb prostheses being provided only by persons recognized by the Canadian Board for Certification of Prosthetists and Orthotists as qualified to fit limb prostheses? ☐ Yes ☐ No
4. **Breast Prosthesis**
   Are breast prostheses being fitted only by persons who have completed training by a breast prosthesis manufacturer in fitting breast prostheses? ☐ Yes ☐ No
5. **Ocular Prosthesis**
   Are ocular prostheses being provided only by persons recognized by the National Examining Board of Ocularists as qualified to fit ocular prostheses? ☐ Yes ☐ No
6. **Orthosis**
   Are orthoses being provided only by persons recognized by the Canadian Board for Certification of Prosthetists and Orthotists as qualified to fit orthoses? ☐ Yes ☐ No

4. SOFTWARE VENDOR

If you use PharmaNet to submit claims, please indicate the type of software used.

Vendor Name	Version

5. OWNER INFORMATION *(all fields in this section are mandatory)*

a. Type of Ownership

☐ Sole Proprietorship ☐ Partnership ☐ Corporation ☐ Health Authority ☐ Other – specify:

b. Registered or Legal Name of Sole Proprietor, Partnership, Corporation or Health Authority

c. Mailing Address	City	Prov	Postal Code

Phone Number	Fax Number	Email Address

d. For business types other than sole proprietorship, please **check type below** and include the **relevant** information, as applicable:
(If you are unsure of what constitutes relevant information, consult your legal counsel)

☐ Partnership: Please provide the list of partners and contact information on **Schedule A: Owner Details**.

☐ B.C. incorporated corporations that are not publicly traded (including subsidiary corporations): Provide a copy of the BC Company Summary, the shareholder's register and any relevant provisions of any shareholder agreements with respect to the operation of the site.

☐ B.C. incorporated corporations that are publicly traded: Provide a copy of the BC Company Summary.

☐ Federally incorporated corporations that are not publicly traded: Provide the names and contact information of all officers and directors on **Schedule A: Owner Details** and provide the shareholder's register and any relevant provisions of any shareholder agreements with respect to the operation of the site.

☐ Federally incorporated corporations that are publicly traded: Provide the names and contact information of all officers and directors on **Schedule A: Owner Details**.

☐ All corporations: a copy of any powers of attorney in respect of the corporation (showing the names and contact information of all persons who may exercise a power of attorney).

6. ADDITIONAL SITES

Please identify any ***owner*** or the ***manager*** of this site who is currently an ***owner*** or ***manager*** of any other site.

Name (First/Last)	Name (First/Last)

Each ***owner*** or ***manager*** named above must complete **Schedule B: Additional Sites**.
Note: As defined in the **Enrollment Guide**, in the case of a corporation, ***owner*** includes the corporation, the directors, the officers and, in the case of a corporation that is not publicly traded, the shareholders. In the case of a subsidiary corporation that is not publicly traded and that has a parent corporation that is not publicly traded, ***owner*** includes the parent corporation and the directors, officers and shareholders of the parent corporation.

7. ADDITIONAL INFORMATION *(all questions in this section are mandatory)*

Please carefully review and answer the following questions.
Note: When a term appears in ***bold italic***, it is a defined term and the meaning can be found in the **Definitions** section of the **Enrollment Guide**.

IMPORTANT: If you answer **Yes** to any of the questions below, please consult the **Enrollment Guide** and complete **Schedule C: Additional Information.**

Pharmacies and Device Providers

1. a. Is any ***owner*** or the ***manager*** of this site currently required to pay any monies to the B.C. government or a ***public insurer*** as a result of a ***relevant audit*** of any site? ☐ Yes ☐ No
   b. Is any entity (e.g., corporation, person) currently required to pay any monies to the B.C. government or a ***public insurer*** as a result of a ***relevant audit*** of any other site that was, *during the audit period*, owned or managed by any ***owner*** or the ***manager*** of this site? ☐ Yes ☐ No
2. a. Has any ***owner*** or the ***manager*** of this site ever been the subject of an order or a conviction for an ***information or billing contravention***? ☐ Yes ☐ No
   b. Has any ***owner*** or the ***manager*** of this site ever been the ***owner*** or ***manager*** of any other site at the time that an ***information or billing contravention*** occurred for which an order or conviction was issued with respect to that other site? ☐ Yes ☐ No
3. a. Are the ***billing privileges*** of any ***owner*** or the ***manager*** of this site currently suspended? ☐ Yes ☐ No
   b. Is any ***owner*** or the ***manager*** of this site currently an ***owner*** or ***manager*** of any other site in respect of which a person's ***billing privileges*** are suspended? ☐ Yes ☐ No
4. a. Has any ***owner*** or the ***manager*** of this site ever had their ***billing privileges*** cancelled? ☐ Yes ☐ No
   b. Was any ***owner*** or the ***manager*** of this site the ***owner*** or ***manager*** of any other site at the time that an incident occurred in relation to that site resulting in the cancellation of ***billing privileges*** for that site? ☐ Yes ☐ No

Pharmacies and Device Providers *(continued)*

5. Has any ***owner*** or the ***manager*** of this site , within the past 6 years, had a judgment entered against them in a court proceeding related to commercial or business activities regarding the provision of drugs, devices, substances or related services at any site? ☐ Yes ☐ No

6. Has any ***owner*** or the ***manager*** of this site, within the past 6 years, been convicted of an offence prescribed in section 22 (1) of the Provider Regulation? (see also section 7, question 6, in **Enrollment Guide**) ☐ Yes ☐ No

7. Has any ***owner*** or the ***manager*** of this site ever had their enrollment in any class of PharmaCare provider cancelled? ☐ Yes ☐ No

8. Has any ***owner*** of this site been a director of a corporation that declared or was petitioned into bankruptcy within the past 6 years? ☐ Yes ☐ No

Pharmacies

9. Has any ***owner*** or the ***manager*** of this site ever had their pharmacy licence suspended or cancelled? *(Please answer both questions).* Suspension: ☐ Yes ☐ No Cancellation: ☐ Yes ☐ No

10. Has any ***owner*** or the ***manager*** of this site ever had their registration as a pharmacist with a governing body of pharmacists suspended or cancelled? *(Please answer both questions).* Suspension: ☐ Yes ☐ No Cancellation: ☐ Yes ☐ No

11. Has any ***owner*** or the ***manager*** of this site ever had any limits or conditions imposed as a result of disciplinary actions taken by a governing body of pharmacists in relation to any site? ☐ Yes ☐ No

Device Providers (including pharmacies that selected "Device Class" in section 2)

12. Has any ***owner*** or the ***manager*** of this site ever had any limits, conditions or prohibitions imposed as a result of disciplinary actions taken by the Canadian Board for Certification of Prosthetists and Orthotists in relation to any site? ☐ Yes ☐ No

8. SIGNATURE OF AUTHORIZED REPRESENTATIVE OF THE APPLICANT *(Mandatory)*

If approved as a PharmaCare Provider, I undertake not to submit false or misleading claims information and acknowledge that doing so is an offence under the *Pharmaceutical Services Act* and its related regulations.

Applicant Signature	Name (First, Last)	Date Signed
	Title	Phone Number

9. MINISTRY APPROVAL (for PharmaCare use only)

Signature	Name (First/Last) and Title
Date Signed	
Level of PharmaNet access granted ☐ Full Access ☐ DIS-only ☐ None	

Provider Type

☐ Enroll as requested **OR** ☐ Enroll as specified:
☐ Do not enroll

- ☐ Pharmacy
  - ☐ Methadone Maintenance Pharmacy
  - ☐ Plan B Pharmacy
- ☐ Devices
  - ☐ Compression Garment Provider
  - ☐ Limb Prosthesis Provider
  - ☐ Breast Prosthesis Provider
  - ☐ Ocular Prosthesis Provider
  - ☐ Orthosis Provider
  - ☐ Insulin Pump Manufacturer / Distributor
  - ☐ Other (ostomy supplies, diabetes supplies)

Submit this form and accompanying documents by mail or fax. If submitting by fax, ensure transmission is legible.

Mail to: PharmaCare Information Support
Health Insurance BC
PO Box 9684, STN PROV GOVT
Victoria BC V8W 9P7

Fax to: 250 405-3599

Personal information on this form is collected by the Ministry of Health under s.22 of the *Pharmaceutical Services Act* for the purpose of determining eligibility for enrolment, and managing ongoing enrolment, as a provider in the PharmaCare program including access to PharmaNet.
If you have any questions about the collection of personal information on this form, contact the Health Insurance BC (HIBC) Chief Privacy Officer at PO Box 9035 STN Prov Govt, Victoria BC V8W 9E3; or call 604 683-7151 (Vancouver) or 1 800 663-7100 (toll free).
This information will be collected, used and disclosed in accordance with the *Freedom of Information and Protection of Privacy Act* and the *Pharmaceutical Services Act*.

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