BRITISH COLUMBIA | Health InsuranceBC

PHARMACARE OSTOMY BENEFITS

INVOICE

INVOICE # _____

Completed forms should be submitted to HIBC: Fax: 250 405-3587 OR Mail to: PharmaCare, PO Box 9655 Stn Prov Govt, Victoria BC V8W 9P2

Invoices for items dispensed during the previous calendar year must be submitted on or before March 31. Claims received after this annual deadline will not be processed.

CLIENT INFORMATION – ENTER LEGAL NAME & PHN AS IT APPEARS ON THE BC SERVICES CARD

CLIENT LEGAL LAST NAME

CLIENT LEGAL FIRST NAME

CLIENT LEGAL SECOND NAME (OR INITIAL)

BIRTHDATE (YYYY / MM / DD)

PERSONAL HEALTH NUMBER (PHN)

REFERRING PHYSICIAN OR NURSE PRACTITIONER

MSP NUMBER

PROVIDER INFORMATION

PROVIDER OPERATING NAME

SITE ID

B C

PROVIDER FAX NUMBER

DETAILED INFORMATION

PIN	DAYS SUPPLY	QTY*	DETAILS	RETAIL COST

*Quantity given must specify units (e.g., g for creams, # items for wipes, pouches, etc.)

TOTAL

DATE DISPENSED (YYYY / MM / DD)

PAYMENT TO CLIENT ☐

CLIENT/AGENT CERTIFICATION

- I have read and understood the information being claimed for on this invoice.
- I agree the above goods and/or services were provided to me.
- I understand that if PharmaCare pays more costs than I was eligible for, I am obligated to repay the extra amount.
- I understand that I am responsible for any outstanding balance.
- I certify that I have undergone bladder or bowel surgery that has resulted in a colostomy, ileostomy, or urostomy, requiring an external pouch.
- I certify that for my own protection, I am not signing a blank form and leaving it on-site for future use.

CLIENT/AGENT SIGNATURE

CLIENT/AGENT NAME (PRINT)

DATE SIGNED (YYYY / MM / DD)

PHARMACIST/HEALTH CARE PROVIDER CERTIFICATION

- I hereby certify that the above goods and/or services have been supplied to my client, on the dispense date above.
- I have explained the above goods and/or services to my client and/or their agent.

SIGNATURE OF PHARMACIST OR HEALTH CARE PROVIDER

COLLEGE OF PHARMACISTS OF BC ID#
OR NAME OF HEALTH CARE PROVIDER (PRINT)

DATE SIGNED (YYYY / MM / DD)

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 financial assistance. 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*.

HLTH 5416 2023/11/22

Save Print Clear Form