BRITISH COLUMBIA | Health InsuranceBC

PHARMACARE MASTECTOMY 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)

DATE OF SURGERY (RIGHT) (YYYY / MM / DD)

DATE OF SURGERY (LEFT) (YYYY / MM / DD)

PROVIDER INFORMATION

PROVIDER OPERATING NAME

SITE ID B C

PROVIDER FAX NUMBER

DETAILED INFORMATION

REFERRING PHYSICIAN

MSP NUMBER

PIN	QTY	DETAILS	COST
		TOTAL	

DATE DISPENSED (YYYY / MM / DD)

PAYMENT TO CLIENT ☐

CLIENT 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 PharmaCare will recover any costs that exceed the amount to which an individual or family is entitled under the PharmaCare plan or benefit eligibility requirements.
- I understand that I am responsible for any outstanding balance.
- I have been advised of PharmaCare's replacement policy. I understand that I will not be eligible for another mastectomy device for this purpose for at least 24 months, and then only upon demonstration that the existing device no longer meets my basic functionality needs.
- I certify that for my own protection, I am not signing a blank form and leaving it on-site for future use.

CLIENT SIGNATURE

CLIENT NAME (PRINT)

DATE SIGNED (YYYY / MM / DD)

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.

SIGNATURE OF HEALTH CARE PROVIDER

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 5415 2022/07/18

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