BRITISH COLUMBIA | Health InsuranceBC

PHARMACARE PROSTHETIC AND ORTHOTIC 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. Page 2 of the approved Application for Financial Assistance must be submitted with this invoice.

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 (see P&O manual section 7.1.2)

MSP NUMBER

PROVIDER INFORMATION

PROVIDER OPERATING NAME

SITE ID B C

PROVIDER FAX NUMBER

DETAILED INFORMATION

☐ DETAILS SAME AS INDICATED ON APPLICATION FOR FINANCIAL ASSISTANCE

DATE OF APPLICATION FOR FINANCIAL ASSISTANCE (YYYY / MM / DD)

DETAILS / PART # / QUANTITY	PHARMACARE APPROVED COST
Total PharmaCare Claim	

QTY | PIN | TOTAL FOR PIN | QTY | PIN | TOTAL FOR PIN

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.
- The health care provider's 90 day warranty and the proper care and maintenance of the device(s) have been explained to me.
- 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 have been advised of PharmaCare's replacement policy. I understand that I will not be eligible for another prosthetic device for this purpose or limb (as applicable) for at least three years, or for another orthotic device for this purpose or limb (as applicable) for at least one year, 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/AGENT SIGNATURE | CLIENT/AGENT NAME (PRINT) | DATE SIGNED (YYYY / MM / DD)

PROSTHETIST/ORTHOTIST 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.
- I hereby certify that the client's casting, fitting and follow-up care is complete.

PROSTHETIST/ORTHOTIST SIGNATURE | CBCPO CERTIFICATION # | 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 5417 2023/12/05

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