



Personal information is collected and used to determine eligibility for PharmaCare financial assistance. The information is collected, used and disclosed in accordance with the Pharmaceutical Services Act and the Freedom of Information and Protection of Privacy Act. If you have any questions about the collection, use and disclosure of this information, please contact HIBC at 250 405-3593 (fax).

Please fax completed form to 250-405-3587 or mail to PharmaCare, PO Box, PO Box 9655 Stn Prov Govt, Victoria BC V8W 9P2

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

Form fields for client information: DATE OF THE ACCIDENT OR INCIDENT (YYYY / MM / DD), CLIENT EMAIL ADDRESS (FOR FASTEST RESPONSE), DAYTIME TELEPHONE NUMBER, CLIENT LEGAL LAST NAME, CLIENT LEGAL FIRST NAME, CLIENT LEGAL SECOND NAME (OR INITIAL), PERSONAL HEALTH NUMBER (PHN), CLIENT HOME ADDRESS AND CITY, POSTAL CODE.

AWARD SETTLEMENT - STATUS

Four status questions with radio buttons: 1. Do you need the device due to a condition... 2. Do you currently have coverage for the device... 3. Did you receive or are you entitled to compensation... 4. Do you intend to pursue or are you currently pursuing compensation...

AWARD/SETTLEMENT DETAILED INFORMATION

You must complete this section if you have received or are entitled to compensation through a court award, settlement agreement or insurance plan.

DATE OF COURT AWARD/SETTLEMENT AGREEMENT/INSURANCE CLAIM PAYMENT (YYYY / MM / DD)

THE COMPENSATION WAS:

Radio buttons for compensation type: LUMP SUM - COMPLETE SECTION A, BROKEN DOWN INTO HEADS OF DAMAGES - COMPLETE SECTION B, OTHER - PROVIDE DETAILS:

A: LUMP SUM

Table with 2 columns: DETAILS OF COURT AWARD/SETTLEMENT/INSURANCE PAYMENT WITH NO SPECIFIC CATEGORY FOR COSTS OF FUTURE CARE, AMOUNT. Rows include: TOTAL AMOUNT OF LUMP SUM RECEIVED, TOTAL AMOUNT OF LUMP SUM SPENT, TOTAL AMOUNT OF LUMP SUM REMAINING.

PHARMACARE ELIGIBILITY AWARDS AND SETTLEMENTS

CLIENT LEGAL LAST NAME

PERSONAL HEALTH NUMBER (PHN)

DATE OF APPLICATION (YYYY / MM / DD)

AWARD/SETTLEMENT DETAILED INFORMATION CONT'D

B: BREAKDOWN OF COMPENSATION WHICH YOU ARE ENTITLED TO OR RECEIVED AND AMOUNT SPENT

Please provide details below of the future care costs as set out in the court award/settlement agreement/insurance claim payment and the total amount spent from each.

DESCRIPTION OF FUTURE CARE COSTS	AMOUNT	AMOUNT SPENT
	\$	\$
	\$	\$
	\$	\$
	\$	\$
	\$	\$
	\$	\$
TOTALS	\$	\$

PharmaCare may require you to:

- provide a copy of the court award/settlement agreement/insurance claim payment.
- prove through a notarized affidavit (or another form acceptable to PharmaCare) that the relevant compensation received has been fully exhausted before you are eligible for PharmaCare benefits.

Please note: It is an offence under Section 51 of the *Pharmaceutical Services Act* to knowingly provide false or misleading information for the purposes of receiving a benefit.

SIGNATURE SECTION

I declare that the information I have provided above is true and subject to verification.

SIGNATURE OF CLIENT

CLIENT NAME (PRINT)

DATE SIGNED (YYYY / MM / DD)

PHARMACARE USE ONLY

MINISTRY OF HEALTH REPRESENTATIVE

DATE SIGNED (YYYY / MM / DD)

- REQUEST APPROVED
 REQUEST NOT APPROVED
 MORE INFORMATION REQUIRED

RETURNED TO CLIENT (YYYY / MM / DD)