

PHARMACARE ORTHOTIC BENEFITS APPLICATION FOR FINANCIAL ASSISTANCE

		DATE OF APPLICATION (YYYY / MM / DD)									
Submit completed forms to HIBC via Fax: 250 405-3590	2										
OR Mail to: PharmaCare, PO Box 9655 Stn Prov Govt, Victoria BC V8W 9P2											
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 PRACTIT	IONER									
LIST OTHER FUNDING AGENCIES INVOLVED (E.G., NON-INSURED HEALTH BENEFITS, ICBC, ETC.)											
DEVICE PROVIDER INFORMATION PROVIDER OPERATING NAME	SITE ID	PROVIDER FAX NUMBER									
	BC										
	PLANNED MGMT OF SPASTICITY / INCREASED TON	E PLANNED INTERVENTION (YYYY / MM / DD)									
	IENTS (CHECK ALL THAT APPLY)	SIDE BEING FITTED									
		RIGHT LEFT BILATERAL									
CURRENT DEVICE (IF ANY) DATE SUI	PPLIED (YYYY / MM / DD)										
DETAILED RATIONALE FOR REQUEST - Include description of biomed	hanical problems to be corrected (attach ad	ditional page if more space required).									
Personal information collected is used to determine eligibility for financial as	sistance. The information is protected from unaut	horized use and disclosure in accordance with the									

Personal information collected is used to determine eligibility for financial assistance. The information is protected from unauthorized use and disclosure in accordance with the *Freedom of Information and Protection of Privacy Act* and may be disclosed only as provided by that Act. If you have any questions about the collection, 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).

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DETAILED INFORMATION																	
	PART # / QUANTITY							PHA	RMA	CARE PI	RICE		Р	ROVID	ER PRIC	CE (IF DIF	FERENT)
													_				
PHARMACARE USE ONLY																	
AMOUNT APPROVED	QTY PIN						TOTAL P	HARM	ACARE	AMOUNT	REQUE	STED	PRO)VIDER TO)TAL (IF C	DIFFERENT)	
REQUEST APPROVED	PHARMACARE PLAN*	DATE	REVIEWED)				AP	PROVA	L ENDS							
				1		1					1		1				
○ REQUEST NOT APPROVED	*(SUBJECT TO CHANGE								TE FAX	ED BAC	ĸ						
	WITHOUT NOTICE).																
COMMENTS															J		

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PHARMACARE ELIGIBI	LITY PERSONAL INJURY										
Client must complete this section for each application even if they were previously approved for PharmaCare coverage. (Note: for your own protection, do not sign blank copies of forms and leave them with your provider for future use. PharmaCare may delay or deny payment to providers who ask their clients to sign blank forms. Clients may then be responsible for payment of the device.).											
Yes No Do you need the device due to a condition (i.e., injury, illness or other) allegedly caused by another person's act or omission? (e.g., motor vehicle crash, accident, or assault) If no, please complete the Client Certification section below. If yes, please answer the following:											
Yes No Do you have an approved PharmaCare form #5467/patient statement already on file? If no, please complete and submit form #5467 to PharmaCare for review of your eligibility. If yes, please answer the following:											
Yes No Have the circumstances of the settlement or award changed since your last application? If yes, please complete and submit form #5467 to PharmaCare for review of your eligibility and complete the Client Certification section below. If no, please complete the Client Certification section below.											
CLIENT/AGENT CERTIF	ICATION										
Please read the follow	/ing statements:										
I have read and understood the information on this application.											
I hereby certify that the information given in this application, and in any documents attached to or forming part of this application, is true and correct.											
I understand that I am responsible for any outstanding balance if the cost of my device and/or service exceeds PharmaCare coverage. My provider has explained the billing to me.											
I understand that if PharmaCare pays more costs than I was eligible for, I am obligated to repay the extra amount.											
I have been advised of PharmaCare's replacement policy. I understand that I will not be eligible for another orthotic device for this limb for at least one year and then only upon demonstration that the existing device no longer meets my basic functionality needs.											
I understand that I must register for Fair PharmaCare before any device and/or service is dispensed to receive income-based Fair PharmaCare coverage. Without registration, my Fair PharmaCare deductible will be \$10,000.00.											
CLIENT/AGENT SI	GNATURE CLIENT/AGENT N	IAME (PRINT)				DATE SIGNED (YYYY / MM / DD)					
ORTHOTIST CERTIFICA	TION										
	at the information on this application is t		•								
• I hereby certify that I am the person responsible for assessing this client. Any services provided to the client by an Orthotics Prosthetics Canada (OPC) resident will have a supervisor on site and adhere to the Scope of Practice set out by OPC.											
I have explained the information on this application to my client and/or their agent.											
						I					
ORTHOTIST SIGN	IATURE ORTHOTIST NA	.ME (PRINT)	СВ	CPO CERTIFICATION #		DATE SIGNED (YYYY / MM / DD)					

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