



BRITISH
COLUMBIA

Ministry of
Health

PHARMACARE
ORTHOTIC BENEFITS
APPLICATION FOR FINANCIAL ASSISTANCE

Submit completed forms to HIBC via Fax: 250 405-3590

OR Mail to: PharmaCare, PO Box 9655 Stn Prov Govt, Victoria BC V8W 9P2

DATE OF APPLICATION (YYYY / MM / DD)

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

CLIENT LEGAL LAST NAME

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CLIENT LEGAL FIRST NAME

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CLIENT LEGAL SECOND NAME (OR INITIAL)

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BIRTHDATE (YYYY / MM / DD)

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PERSONAL HEALTH NUMBER (PHN)

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REFERRING PHYSICIAN OR NURSE PRACTITIONER

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LIST OTHER FUNDING AGENCIES INVOLVED (E.G., NON-INSURED HEALTH BENEFITS, ICBC, ETC.)

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DEVICE PROVIDER INFORMATION

PROVIDER OPERATING NAME

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SITE ID

B	C																		
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PROVIDER FAX NUMBER

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SERVICE INFORMATION

REQUEST (CHECK ONE)

<input type="radio"/> INITIAL*	<input type="radio"/> REPLACEMENT	<input type="radio"/> REPAIR	<input type="radio"/> ADJUSTMENT	*(Requires Rx)
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PLANNED MGMT OF SPASTICITY / INCREASED TONE

<input type="checkbox"/> MEDICAL (ORAL, INJECTABLE)	<input type="checkbox"/> SURGICAL
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PLANNED INTERVENTION (YYYY / MM / DD)

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CAUSE / DIAGNOSIS

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ATTACHMENTS (CHECK ALL THAT APPLY)

<input type="checkbox"/> LOWER LIMB MEASUREMENTS	<input type="checkbox"/> Rx
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SIDE BEING FITTED

<input type="checkbox"/> RIGHT	<input type="checkbox"/> LEFT	<input type="checkbox"/> BILATERAL
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CURRENT DEVICE (IF ANY)

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DATE SUPPLIED (YYYY / MM / DD)

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DETAILED RATIONALE FOR REQUEST - Include description of biomechanical problems to be corrected (attach additional page if more space required).

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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).

CLIENT LEGAL LAST NAME

PERSONAL HEALTH NUMBER (PHN)

DATE OF APPLICATION (YYYY / MM / DD)

DETAILED INFORMATION		
DETAILS / PART # / QUANTITY	PHARMACARE PRICE	PROVIDER PRICE (IF DIFFERENT)

PHARMACARE USE ONLY

AMOUNT APPROVED

☐ REQUEST APPROVED

☐ MORE INFORMATION REQUIRED

☐ REQUEST NOT APPROVED

QTY

PIN

TOTAL PHARMACARE AMOUNT REQUESTED

PROVIDER TOTAL (IF DIFFERENT)

PHARMACARE PLAN*

DATE REVIEWED

APPROVAL ENDS

DATE FAXED BACK

COMMENTS

*(SUBJECT TO CHANGE WITHOUT NOTICE).

DATE OF APPLICATION (YYYY / MM / DD)

Day	Number of people
Monday	2
Tuesday	3
Wednesday	2
Thursday	4
Friday	2
Saturday	4
Sunday	2

 ORTHOTIST SIGNATURE ORTHOTIST NAME (PRINT) CBCPO CERTIFICATION # DATE SIGNED (YYYY / MM / DD)

CLIENT LEGAL LAST NAME

PERSONAL HEALTH NUMBER (PHN)

DATE OF APPLICATION (YYYY / MM / DD)

LOWER LIMB ORTHOTIC MEASUREMENT

The Lower Limb Orthotic Measurement page **MUST** be completed and submitted with **EACH** lower limb orthosis request.

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WIDTH

○

CIRCUMFERENCE

□

LENGTH

Note: Please provide all measurements in cm.

	LEFT	RIGHT
TIBIAL TORSION		
DEGREE OF TOE OUT		
DISTANCE TO MEDIAL MALLEOLUS		
DISTANCE TO LATERAL MALLEOLUS		

For all ankle-foot orthosis (AFO) / Supramalleolar orthosis (SMO) applications, include the following measurements: **Areas 4, 5, 6, 7, and 8.**

For all knee-ankle-foot orthosis (KAFO) applications, include the following measurements: **Areas 1, 2, 3, 4, 5, 6, 7, and 8.**

For all hip-knee-ankle-foot orthosis (HKAFO) applications, include the following measurements: **Areas 1, 2, 3, 4, 5, 6, 7, 8, and 9.**