BRITISH COLUMBIA | Health InsuranceBC

PHARMACARE

PROSTHETIC BENEFITS (NON-LIMB) APPLICATION FOR FINANCIAL ASSISTANCE

Completed forms should be submitted to HIBC: Fax: 250 405-3590
OR Mail to: PharmaCare, PO Box 9655 Stn Prov Govt, Victoria BC V8W 9P2

DATE OF APPLICATION (YYYY / MM / DD)

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

LIST OTHER AGENCIES FROM WHICH CLIENT RECEIVES COVERAGE (E.G., VETERANS AFFAIRS, ICBC)

DEVICE PROVIDER INFORMATION

PROVIDER OPERATING NAME

SITE ID

B C

PROVIDER FAX NUMBER

SERVICE INFORMATION

REQUEST

☐ INITIAL* ☐ REPLACEMENT ☐ REPAIR ☐ ADJUSTMENT **Requires Rx*

TYPE OF DEVICE REQUESTED

ATTACHMENTS? (CHECK ALL THAT APPLY)

☐ RX ☐ OTHER

CAUSE / DIAGNOSIS

CURRENT DEVICE (IF ANY)

DATE SUPPLIED (YYYY / MM / DD)

RATIONALE FOR REQUEST - PROVIDE DETAILS ON THE ITEMS REQUESTED AND THE ESTIMATED COST OF EACH ITEM

PHARMACARE USE ONLY

AMOUNT APPROVED

AMOUNT APPROVED

QTY

PIN

TOTAL PHARMACARE AMOUNT REQUESTED

QTY

PIN

TOTAL PHARMACARE AMOUNT REQUESTED

☐ REQUEST APPROVED
☐ MORE INFORMATION REQUIRED
☐ REQUEST NOT APPROVED

PHARMACARE PLAN*

*(SUBJECT TO CHANGE WITHOUT NOTICE).

DATE REVIEWED

APPROVAL ENDS

DATE FAXED BACK

COMMENTS

PROSTHETIC BENEFITS (NON-LIMB): APPLICATION FOR FINANCIAL ASSISTANCE

CLIENT LEGAL LAST NAME

PERSONAL HEALTH NUMBER (PHN)

DATE OF APPLICATION (YYYY / MM / DD)

PHARMACARE ELIGIBILITY PERSONAL INJURY

You must complete this section for each application even if you 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 CERTIFICATION

Please read the following:

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 PharmaCare will recover any costs that exceed the amount I am entitled to under the PharmaCare plan or benefits eligibility requirements.

I have been advised of PharmaCare's replacement policy. I understand that I will not be eligible for another prosthetic device **for at least three years** 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 SIGNATURE

CLIENT/AGENT NAME (PRINT)

DATE SIGNED (YYYY / MM / DD)

PROSTHETIST CERTIFICATION

- I hereby certify that the information on this application is true, correct and complete to the best of my knowledge.
- I hereby certify that I am the person responsible for assessing, fitting, and caring for this client.
- I have explained the information on this application to this client.

SIGNATURE OF HEALTH CARE PROFESSIONAL

PRINT NAME OF HEALTH CARE PROFESSIONAL

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*.

Save Print Clear Form