BRITISH COLUMBIA | Health InsuranceBC
The Best Place on Earth

PHARMACARE

ORTHOTIC BENEFITS
APPLICATION FOR FINANCIAL ASSISTANCE

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, use and disclosure of this information, please fax to 250 405-3593.

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

PHARMACARE USE ONLY

DATE FAXED TO HEALTH CARE PROVIDER (YYYY / MM / DD)

PATIENT INFORMATION

PATIENT LEGAL LAST NAME

PATIENT LEGAL FIRST NAME

PATIENT LEGAL SECOND NAME (OR INITIAL)

BIRTHDATE (YYYY / MM / DD)

PERSONAL HEALTH (CARECARD) NUMBER

DATE OF APPLICATION (YYYY / MM / DD)

LOWER LIMB MEASUREMENT ATTACHED
☐ YES ☐ NO

HEALTH CARE PROVIDER INFORMATION

FACILITY

PHARMACY EQUIVALENCY CODE
B C

FACILITY FAX NUMBER

SERVICE INFORMATION

REQUEST
☐ INITIAL ☐ REPLACEMENT ☐ REPAIR ☐ ADJUSTMENT

PLANNED MGMT OF SPASTICITY / INCREASED TONE
☐ MEDICAL (ORAL, INJECTABLE) ☐ SURGICAL

DATE OF INTERVENTION (YYYY / MM / DD)

CAUSE / DIAGNOSIS

CURRENT DEVICE

DATE SUPPLIED (YYYY / MM / DD)

REFERRING PHYSICIAN / TEAM LEAD

RATIONALE FOR REQUEST - INCLUDE DESCRIPTION OF BIOMECHANICAL PROBLEMS TO BE CORRECTED (ATTACH ADDITIONAL PAGE IF MORE SPACE REQUIRED)

APPLICATION FOR FINANCIAL ASSISTANCE: ORTHOTIC BENEFITS

PATIENT LEGAL LAST NAME

PERSONAL HEALTH (CARECARD) NUMBER

DATE OF APPLICATION (YYYY / MM / DD)

SIDE BEING FITTED

☐ RIGHT ☐ LEFT ☐ BILATERAL

ATTACHMENTS?

☐ WORK ORDER ☐ RX

WORK ORDER #

DETAILED INFORMATION

REQUEST	DETAILS / PART # / QUANTITY	COST
Type of Orthosis		
Number and type of custom straps or parts required		

QTY

PIN NUMBER

ESTIMATED TOTAL

PATIENT / AGENT CERTIFICATION

- I have read and understood the information on this application.
- I hereby certify that the information given in this application for benefits, and in any documents attached or forming part of this application, is true and correct.
- I understand that PharmaCare will recover any costs that exceed the amount to which an individual or family is entitled under the PharmaCare plan or benefit eligibility requirements.
- 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 am responsible for any outstanding balance.

SIGNATURE OF PATIENT OR THEIR AGENT

PRINT NAME OF SIGNATORY

DATE SIGNED (YYYY / MM / DD)

ORTHOTIST 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 professional responsible for assessing, fitting, and caring for this patient and, as such, will complete the patient's assessment, casting, fitting and follow-up care. Any services provided to the patient by a CBCPO resident will be under my direct supervision.
- I have explained the information on this application to my patient and/or their agent.

SIGNATURE OF ORTHOTIST

CBCPO CERTIFICATION #

DATE SIGNED (YYYY / MM / DD)

PHARMACARE USE ONLY

☐ REQUEST APPROVED

☐ MORE INFORMATION REQUIRED (SEE COMMENTS ATTACHED)

☐ REQUEST NOT APPROVED (SEE COMMENTS ATTACHED)

PHARMACARE PLAN

AMOUNT APPROVED

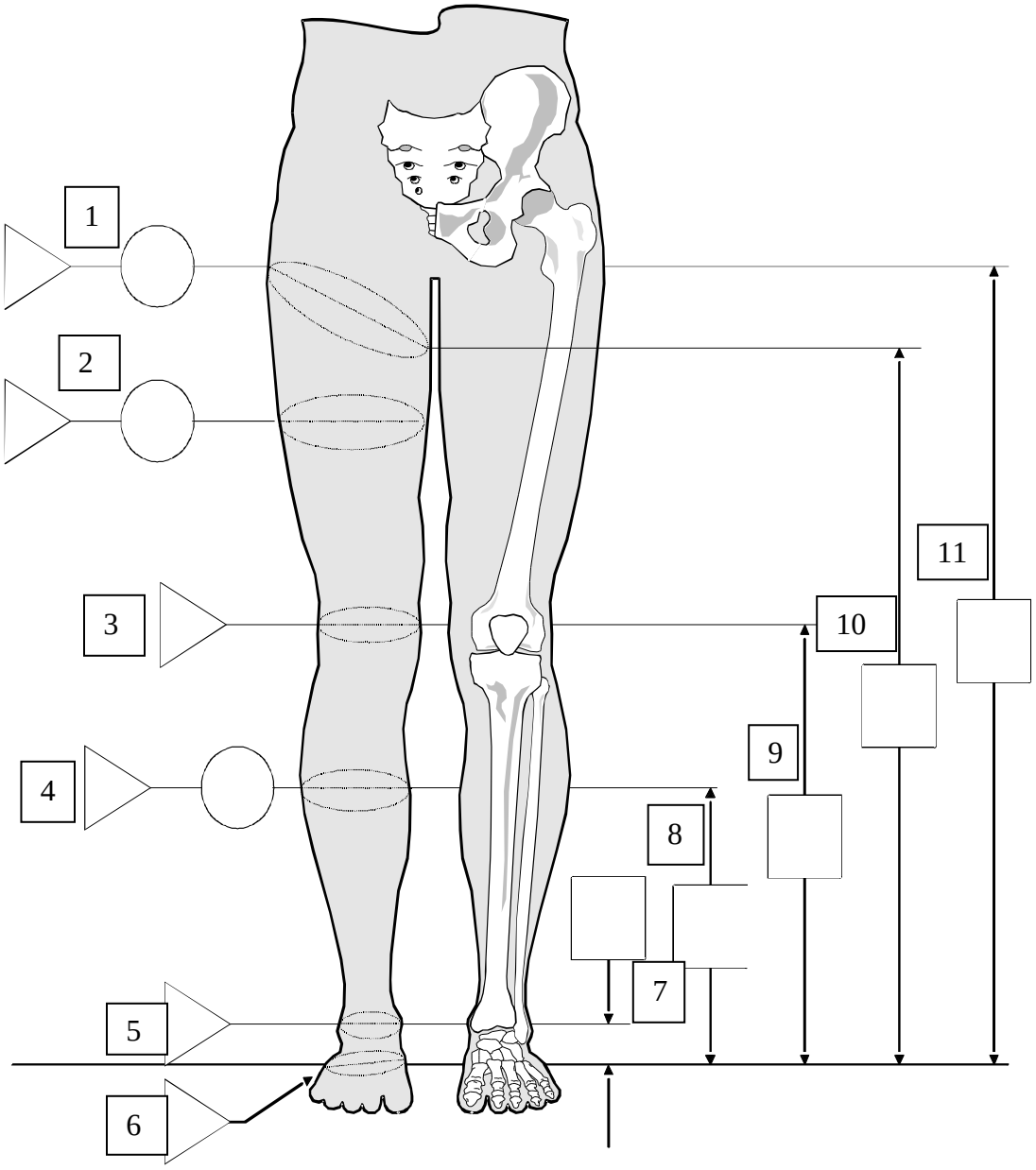
DATE REVIEWED (YYYY / MM / DD)

PRINT

RESET

PATIENT LEGAL LAST NAME | PERSONAL HEALTH (CARECARD) NUMBER | DATE OF APPLICATION (YYYY/MM/DD)

Lower Limb Orthotic Measurement



Distance

Circumference

Diameter

Degree of toe out:_____ Shoe size:_____

Tibial Torsion:

Distance to Medial Malleolus:_____

Distance to Lateral Malleolus:_____