BRITISH COLUMBIA | Ministry of Health

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 HIBC at 250 405-3593.

DATE OF APPLICATION (YYYY / MM / DD)

Submit completed forms to HIBC via Fax: 250 405-3590
OR Mail to: PharmaCare, PO Box 9655 Stn Prov Govt, Victoria BC V8W 9P2

CLIENT INFORMATION – ENTER LEGAL NAME AND 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 / TEAM LEAD

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

DEVICE PROVIDER INFORMATION

PROVIDER OPERATING NAME

SITE ID

B C

PROVIDER FAX NUMBER

SERVICE INFORMATION

REQUEST (CHECK ONE)

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

PLANNED MGMT OF SPASTICITY / INCREASED TONE

☐ MEDICAL (ORAL, INJECTABLE) ☐ SURGICAL

PLANNED INTERVENTION (YYYY / MM / DD)

CAUSE / DIAGNOSIS

ATTACHMENTS (CHECK ALL THAT APPLY)

☐ LOWER LIMB MEASUREMENTS ☐ Rx

SIDE BEING FITTED

☐ RIGHT ☐ LEFT ☐ BILATERAL

CURRENT DEVICE (IF ANY)

DATE SUPPLIED (YYYY / MM / DD)

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

ORTHOTIC BENEFITS: APPLICATION FOR FINANCIAL ASSISTANCE

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

QTY

PIN

TOTAL PHARMACARE AMOUNT REQUESTED

PROVIDER TOTAL (IF DIFFERENT)

☐ REQUEST APPROVED
☐ MORE INFORMATION REQUIRED
☐ REQUEST NOT APPROVED

PHARMACARE PLAN*

*(SUBJECT TO CHANGE WITHOUT NOTICE).

DATE REVIEWED

APPROVAL ENDS

DATE FAXED BACK

COMMENTS

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 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 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 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 SIGNATURE | CLIENT/AGENT NAME (PRINT) | 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 person responsible for assessing, fitting, and caring for this client and, as such, will complete the client's assessment, casting, fitting and follow-up care. Any services provided to the client by a CBCPO resident will be under my direct supervision.
- I have explained the information on this application to my client and/or their agent.

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

ORTHOTIC BENEFITS: APPLICATION FOR FINANCIAL ASSISTANCE

CLIENT LEGAL LAST NAME

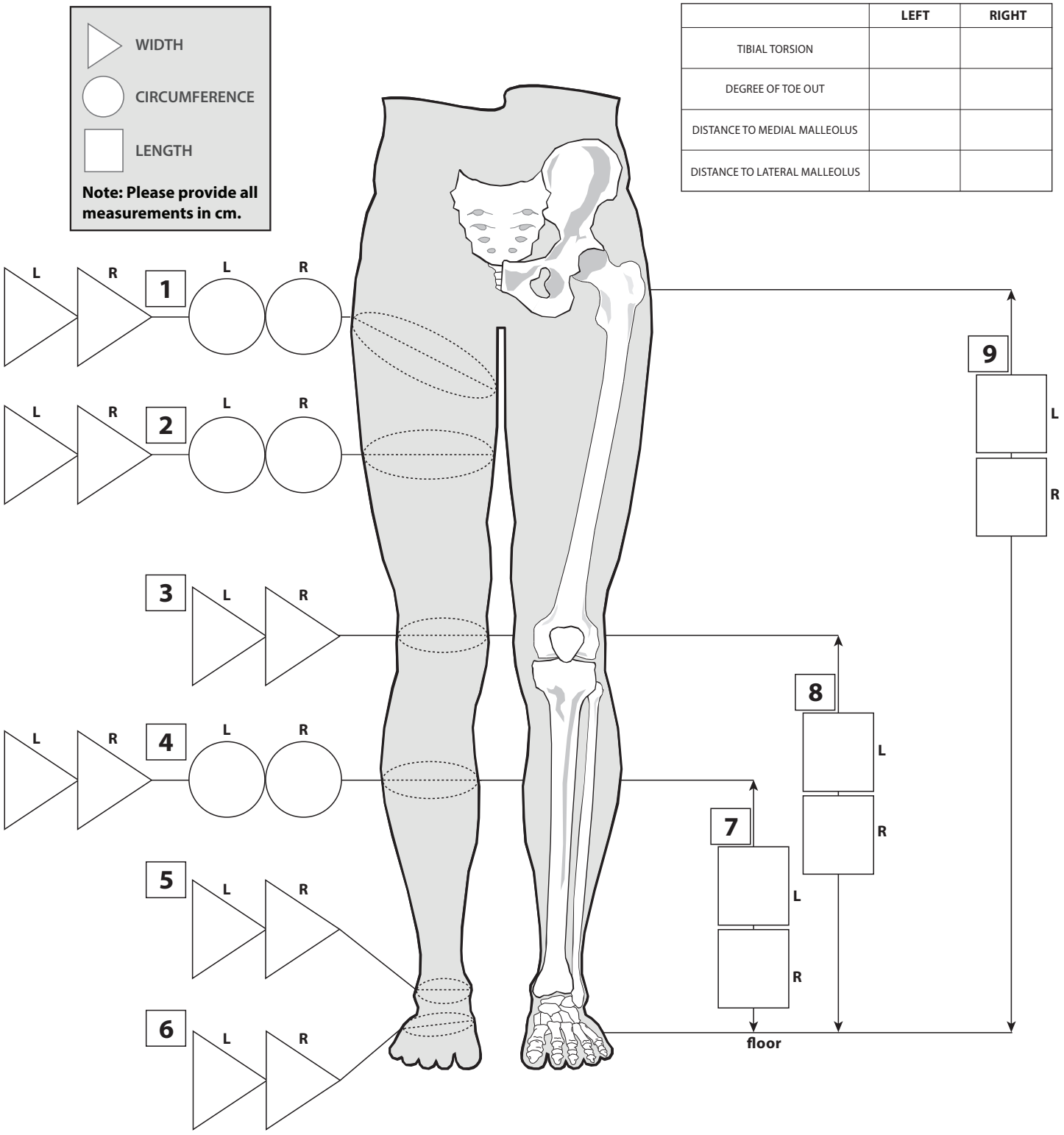
PERSONAL HEALTH NUMBER (PHN)

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.

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



For all ankle-foot orthosis **(AFO)** 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.**

Print Clear Form