BRITISH COLUMBIA | Health InsuranceBC
The Best Place on Earth

PHARMACARE ORTHOTIC BENEFITS
INVOICE

INVOICE # _____

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: 250 405-3587 OR Mail to: Pharmacare, PO Box 9655 Stn Prov Govt, Victoria BC V8W 9P2

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 DISPENSED (YYYY / MM / DD) | PAYMENT

☐ PATIENT

HEALTH CARE PROVIDER INFORMATION

FACILITY | PHARMACY EQUIVALENCY CODE (B C) | CONTACT TELEPHONE NUMBER

REFERRING PHYSICAN | MSP NUMBER

DETAILED INFORMATION

☐ SAME AS DETAILS ON ORTHOTIC BENEFITS – APPLICATION FOR FINANCIAL ASSISTANCE

DATE OF APPLICATION YYYY / MM / DD

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

QTY | PIN NUMBER | TOTAL CLAIM

PATIENT / AGENT CERTIFICATION

- I have read and understood the information being claimed for on this invoice.
- I accept the above goods and/or services were provided to me.
- The health care provider's 90 day warranty and the proper care and maintenance of the device(s) has been explained to me.
- 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 understand that I am responsible for any outstanding balance.
- I have been advised of PharmaCare's replacement policy. I understand that I will not be eligible for another orthotic device for this limb(s) for at least one year and then only upon demonstration that the existing device no longer meets my basic functionality needs.

SIGNATURE OF PATIENT OR THEIR AGENT | PRINT NAME OF SIGNATORY | DATE SIGNED (YYYY / MM / DD)

ORTHOTIST CERTIFICATION

- I hereby certify that the above goods and/or services have been supplied to my patient.
- I have explained the above goods and/or services to my patient and/or their agent.

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

PRINT RESET