BRITISH COLUMBIA | Health InsuranceBC
The Best Place on Earth

PHARMACARE
PROSTHETIC 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 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

DATE OF APPLICATION (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

PATIENT WEIGHT (WITHOUT PROSTHESIS)

DATE TAKEN (YYYY / MM / DD)

HEALTH CARE PROVIDER INFORMATION

FACILITY

PHARMACY EQUIVALENCY CODE
B C

FACILITY FAX NUMBER

SERVICE INFORMATION

REQUEST

☐ INITIAL ☐ REPLACEMENT ☐ UPGRADE ☐ COSMESIS ☐ REPAIR ☐ ADJUSTMENT ☐ SUPPLIES

LEFT LEVEL

CAUSE / DIAGNOSIS

DATE (YYYY / MM)

RIGHT LEVEL

CAUSE / DIAGNOSIS

DATE (YYYY / MM)

PRIMARY MEANS OF MOBILITY (PLEASE PRIORITIZE)

COMMUNITY: ____ CRUTCHES ____ PROSTHESIS ____ WHEELCHAIR ____ OTHER (SPECIFY):

HOUSEHOLD: ____ CRUTCHES ____ PROSTHESIS ____ WHEELCHAIR ____ OTHER (SPECIFY):

☐ TEAM ASSESSMENT ☐ AMPUTEE CLINIC VISIT ☐ PATIENT VISIT

DATE OF VISIT (YYYY / MM / DD)

ATTACHMENTS

☐ MEDICAL REPORT ☐ Rx ☐ WORK ORDER

REFERRING PHYSICIAN / TEAM LEAD

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

FOR REPAIRS COSTING $400 OR MORE, PROVIDE DETAILS ON REASONS FOR REPAIR AND EXPECTED LENGTH OF TIME PATIENT WILL USE REPAIRED ITEM LISTED IN THE PROSTHETIC APPLICATION FORM

DETAILED RATIONALE FOR REQUEST

APPLICATION FOR FINANCIAL ASSISTANCE: PROSTHETIC BENEFITS

PATIENT LEGAL LAST NAME

PERSONAL HEALTH (CARECARD) NUMBER

DATE OF APPLICATION (YYYY / MM / DD)

DETAILED INFORMATION

LAST SUPPLIED

DATE (YYYY / MM / DD)

SIDE BEING FITTED

☐ LEFT ☐ RIGHT ☐ BILATERAL

WORK ORDER #

COMPONENT/PROCEDURE	DETAILS / PART # / QUANTITY	COST
Socket		
Socket Insert / Liners		
Check Socket		
Foot, TD		
Ankle, Wrist		
Knee, Elbow, Hip		
Suspension, Harness		
Cosmetic Finish		
Socks, etc.		

PHARMACARE USE ONLY

APPROVED AMOUNT

PIN NUMBER

ESTIMATED TOTAL

PHARMACARE USE ONLY

☐ REQUEST APPROVED

☐ MORE INFORMATION REQUIRED (SEE COMMENTS BELOW)

☐ REQUEST NOT APPROVED (SEE COMMENTS BELOW)

PHARMACARE PLAN

DATE REVIEWED (YYYY / MM / DD)

DATE FAXED BACK TO HCP (YYYY / MM / DD)

COMMENTS

APPLICATION FOR FINANCIAL ASSISTANCE: PROSTHETIC BENEFITS

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

PAST MEDICAL HISTORY – REQUIRED FOR INITIAL AND UPGRADED REQUESTS

- ☐ DIALYSIS
- ☐ DIABETES
- ☐ VASCULAR DISEASE (EXAMPLE: STROKE, VASCULAR BYPASS, PERIPHERAL VASCULAR DISEASE)
- ☐ CARDIOVASCULAR RISK FACTORS (EXAMPLE: HEART ATTACK, PACEMAKER, CONGESTIVE HEART FAILURE, HYPERTENSION)
- ☐ CHRONIC RESPIRATORY DISEASE (EXAMPLE: CHRONIC OBSTRUCTIVE PULMONARY DISEASE)
- ☐ ARTHRITIS
- ☐ NEURO (EXAMPLE: SPINAL CORD, MULTIPLE SCLEROSIS)
- ☐ COGNITIVE IMPAIRMENT
- ☐ DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 4TH EDITION, (EXAMPLE: PSYCHIATRIC DIAGNOSIS)
- ☐ OTHER (EXAMPLE: INJURY TO OTHER LIMB) (SPECIFY): _____
- ☐ PREVIOUS AMPUTATION(S) (SPECIFY): _____

UPPER EXTREMITY AMPUTEE - SUPPLEMENTARY INFORMATION

DOMINANT LIMB: ☐ YES ☐ NO

RESIDUAL LIMB DEFORMITY: ☐ YES ☐ NO

EXPLAIN

PROSTHESIS TYPE REQUESTED: ☐ CONVENTIONAL ☐ ELECTRIC

RATIONALE FOR DECISION: ☐ FUNCTIONAL ☐ COSMESIS ☐ OTHER (SPECIFY):

PATIENT RETURNING TO WORK: ☐ YES ☐ NO

PATIENT BEING RETRAINED: ☐ YES ☐ NO

OCCUPATION

PATIENT ASSESSED IN AMPUTEE CLINIC: ☐ YES ☐ NO

LOCATION

DATE (YYYY / MM / DD)

ELECTRO/MYO-ELECTRIC TRAINING BY | QUALIFICATION | DATE (YYYY / MM / DD)

FUNCTIONAL TRAINING BY | QUALIFICATION | DATE (YYYY / MM / DD)

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 prosthetic device for this limb 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 am responsible for any outstanding balance.

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

PROSTHETIST CERTIFICATION

- I hereby certify that the information on this applicaton is true, correct and complete to the best of my knowledge.
- I hereby certify that I am the professional responsible for the 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 PROSTHETIST | CBCPO CERTIFICATION # | DATE SIGNED (YYYY / MM / DD)

PRINT RESET