BRITISH COLUMBIA | Health InsuranceBC

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 to HIBC at 250 405-3593.

Submit completed forms to HIBC via 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 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

CLIENT WEIGHT (WITHOUT PROSTHESIS)

DATE TAKEN (YYYY / MM / DD)

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

DEVICE PROVIDER INFORMATION

PROVIDER OPERATING NAME

SITE ID

B C

PROVIDER FAX NUMBER

SERVICE INFORMATION

Provider must also complete schedule 'B' if requesting an upper extremity device.

REQUEST (CHECK ONE)

☐ INITIAL* ☐ REPLACEMENT ☐ UPGRADE* ☐ COSMESIS ☐ REPAIR ☐ ADJUSTMENT ☐ SUPPLIES (*REQUIRES SCHEDULE 'A' AND Rx)

LEFT LEVEL

CAUSE / DIAGNOSIS

DATE OF AMPUTATION (YYYY / MM)

RIGHT LEVEL

CAUSE / DIAGNOSIS

DATE OF AMPUTATION (YYYY / MM)

☐ TEAM ASSESSMENT ☐ AMPUTEE CLINIC VISIT ☐ CLIENT VISIT

DATE OF VISIT (YYYY / MM / DD)

ATTACHMENTS

☐ MEDICAL REPORT ☐ Rx ☐ WORK ORDER

DETAILED RATIONALE FOR REQUEST – SEE POLICY MANUAL FOR MORE INFORMATION

Attach additional page if more space required.

PROSTHETIC BENEFITS: APPLICATION FOR FINANCIAL ASSISTANCE

CLIENT LEGAL LAST NAME

PERSONAL HEALTH NUMBER (PHN)

DATE OF APPLICATION (YYYY / MM / DD)

DETAILS OF REQUEST

LAST SUPPLIED

DATE (YYYY / MM / DD)

PHARMACARE USE ONLY

APPROVED AMOUNT

☐ REQUEST APPROVED
☐ MORE INFORMATION REQUIRED
☐ REQUEST NOT APPROVED

SIDE BEING FITTED

☐ LEFT ☐ RIGHT ☐ BILATERAL

PIN

TOTAL PHARMACARE AMOUNT REQUESTED

WORK ORDER # (OR ATTACH SCHEDULE 'C')

PIN

TOTAL PHARMACARE AMOUNT REQUESTED

☐ RESUBMISSION

RESUBMIT DATE (YYYY / MM / DD)

PHARMACARE PLAN*

DATE REVIEWED

DATE FAXED BACK

APPROVAL ENDS

*(SUBJECT TO CHANGE WITHOUT NOTICE).

COMMENTS

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 on the next page.*** **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 on the next page.*** **If no, please complete the Client Certification section on the next page.**

PROSTHETIC BENEFITS: APPLICATION FOR FINANCIAL ASSISTANCE

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

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 what 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 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 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.

I hereby certify that I have read each statement above and understand each statement to be true.

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 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.

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

SCHEDULE 'A' - MUST BE SUBMITTED WITH ALL INITIAL AND UPGRADED REQUESTS

PAST MEDICAL HISTORY - MAY BE COMPLETED BY CLIENT, OR BY PROVIDER BASED ON CLIENT/PRACTITIONER INPUT

Please check all that apply:

- ☐ DIALYSIS
- ☐ DIABETES
- ☐ VASCULAR DISEASE (E.G., STROKE, VASCULAR BYPASS, PERIPHERAL VASCULAR DISEASE)
- ☐ CARDIOVASCULAR RISK FACTORS (E.G., HEART ATTACK, PACEMAKER, CONGESTIVE HEART FAILURE, HYPERTENSION)
- ☐ CHRONIC RESPIRATORY DISEASE (E.G., CHRONIC OBSTRUCTIVE PULMONARY DISEASE)
- ☐ REVISION SURGERY (REQUIRES Rx)
- ☐ ARTHRITIS
- ☐ NEURO (E.G., SPINAL CORD, MULTIPLE SCLEROSIS)
- ☐ COGNITIVE IMPAIRMENT
- ☐ DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS, 4TH EDITION, (E.G., PSYCHIATRIC DIAGNOSIS)
- ☐ OTHER (E.G., INJURY TO OTHER LIMB) (SPECIFY): _____
- ☐ PREVIOUS AMPUTATION(S) (SPECIFY): _____
- ☐ NONE

PROSTHETIC BENEFITS: APPLICATION FOR FINANCIAL ASSISTANCE

CLIENT LEGAL LAST NAME

PERSONAL HEALTH NUMBER (PHN)

DATE OF APPLICATION (YYYY / MM / DD)

SCHEDULE 'B' - MUST BE SUBMITTED WITH ALL UPPER EXTREMITY REQUESTS

UPPER EXTREMITY AMPUTEE – SUPPLEMENTARY INFORMATION – TO BE COMPLETED BY PROVIDER

DOMINANT LIMB ☐ YES ☐ NO

RESIDUAL LIMB DEFORMITY ☐ YES ☐ NO

DETAIL NATURE AND EXTENT OF RESIDUAL LIMB DEFORMITY

PROSTHESIS TYPE REQUESTED ☐ CONVENTIONAL ☐ ELECTRIC

RATIONALE FOR TYPE REQUEST ☐ FUNCTIONAL ☐ COSMESIS ☐ OTHER (SPECIFY):

CLIENT RETURNING TO WORK ☐ YES ☐ NO

CLIENT BEING RETRAINED ☐ YES ☐ NO

OCCUPATION – CURRENT IF RETURNING TO WORK, OR NEW IF BEING RETRAINED

CLIENT ASSESSED IN AMPUTEE CLINIC ☐ YES ☐ NO

LOCATION OF AMPUTEE CLINIC

DATE (YYYY / MM / DD)

ELECTRO/MYO-ELECTRIC TRAINING BY

PRACTITIONER'S QUALIFICATION

QUALIFICATION DATE (YYYY / MM / DD)

FUNCTIONAL TRAINING BY

PRACTITIONER'S QUALIFICATION

QUALIFICATION DATE (YYYY / MM / DD)

SCHEDULE 'C' - TO BE COMPLETED AND SUBMITTED ONLY IF A WORK ORDER IS NOT BEING SUBMITTED

DETAILED INFORMATION

COMPONENT/PROCEDURE	DETAILS / PART # / QUANTITY	PHARMACARE PRICE	PROVIDER PRICE (IF DIFFERENT)
Socket			
Socket Insert / Liners			
Check Socket			
Foot, TD			
Ankle, Wrist			
Knee, Elbow, Hip			
Suspension, Harness			
Cosmetic Finish			
Socks, etc.			

PIN

TOTAL PHARMACARE AMOUNT REQUESTED

PROVIDER TOTAL (IF DIFFERENT)

Print

Clear Form