



PHARMACARE PROSTHETIC BENEFITS (NON-LIMB) APPLICATION FOR FINANCIAL ASSISTANCE

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)

Grid for date of application

CLIENT INFORMATION - ENTER LEGAL NAME & 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

LIST OTHER AGENCIES FROM WHICH CLIENT RECEIVES COVERAGE (E.G., VETERANS AFFAIRS, ICBC)

DEVICE PROVIDER INFORMATION

PROVIDER OPERATING NAME, SITE ID (with B C), PROVIDER FAX NUMBER

SERVICE INFORMATION

REQUEST (INITIAL*, REPLACEMENT, REPAIR, ADJUSTMENT *Requires Rx), TYPE OF DEVICE REQUESTED, ATTACHMENTS? (CHECK ALL THAT APPLY) (RX, OTHER)

CAUSE / DIAGNOSIS, CURRENT DEVICE (IF ANY), DATE SUPPLIED (YYYY / MM / DD)

RATIONALE FOR REQUEST - PROVIDE DETAILS ON THE ITEMS REQUESTED AND THE ESTIMATED COST OF EACH ITEM

PHARMACARE USE ONLY

AMOUNT APPROVED, QTY, PIN, TOTAL PHARMACARE AMOUNT REQUESTED (repeated)

REQUEST APPROVED, MORE INFORMATION REQUIRED, REQUEST NOT APPROVED, PHARMACARE PLAN*, DATE REVIEWED, APPROVAL ENDS, DATE FAXED BACK

COMMENTS

