BRITISH COLUMBIA | Health InsuranceBC
The Best Place on Earth

PHARMACARE

PROSTHETIC BENEFITS (NON-LIMB) 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

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 OF APPLICATION (YYYY / MM / DD) | RX ATTACHED? ☐ YES ☐ NO

HEALTH CARE PROVIDER INFORMATION

FACILITY | PHARMACY EQUIVALENCY CODE (B C) | FACILITY FAX NUMBER

SERVICE INFORMATION

CAUSE / DIAGNOSIS | CURRENT DEVICE | DATE SUPPLIED (YYYY / MM / DD)

REFERRING PHYSICIAN | LIST OTHER AGENCIES FROM WHICH PATIENT RECEIVES COVERAGE (E.G., VETERANS AFFAIRS, ICBC)

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

QTY | PIN NUMBER | ESTIMATED TOTAL | QTY | PIN NUMBER | ESTIMATED TOTAL

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 understand my entitlements under the PharmaCare program, and they have been clearly explained by my health care provider.
- 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)

HEALTH CARE PROFESSIONAL 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 will be the person responsible for the assessing, fitting, and caring for this patient.
- I have explained the information on this application to my patient and/or their agent.

SIGNATURE OF HEALTH CARE PROFESSIONAL | PRINT NAME OF HEALTH CARE PROFESSIONAL | DATE SIGNED (YYYY / MM / DD)

DATE FAXED TO HEALTH CARE PROVIDER (YYYY / MM / DD)

PHARMACARE USE ONLY

☐ REQUEST APPROVED
☐ MORE INFORMATION REQUIRED (SEE COMMENTS ATTACHED)
☐ REQUEST NOT APPROVED (SEE COMMENTS ATTACHED)

PHARMACARE PLAN | AMOUNT APPROVED | DATE (YYYY / MM / DD)

PRINT RESET