

## What you need to know about...

### PharmaCare Prosthetic Benefits (Non-Limb): Application for Financial Assistance

(Health Form #5404)

#### General Instructions

- Health care providers must apply for pre-approval for their patients for all benefits valued at \$400 or more. **PharmaCare does not cover any item at or above that value unless pre-approval has been granted.**
- Pre-approval is valid for 6 months from the date noted on the approved form returned to the health care provider.
- Include a prescription authorizing the device. More complex cases may require a prescription from a specialist physician.
- The form is designed to capture the functional need for the device/service.
- Please forward all appropriate documentation with the form when it is sent for pre-approval.
- **Remember to sign the form before sending it.**

#### Send completed and signed forms to:

Health Insurance British Columbia, Practitioner & Patient Services

Fax: **250 405-3590**

Mail: PharmaCare  
PO Box 9655 Stn Prov Govt  
Victoria BC V8W 9P2

**Note:** Any notes written outside the boxes on the application form may not be visible when faxed.

## Resubmitted Applications

Sometimes an application has to be resubmitted to address questions from the Prosthetic and Orthotic Committee or to address the patient's changing health needs. In these cases, please:

- 1) Create a new form (or copy your original) – this “new” form should not have any information in the **PharmaCare Use Only** portion of the application. This “new” form should include any changes that you are making to the **Detailed Information** section.
- 2) Mark “Resubmitted” in block letters above the **Date of Application** field at the top of this “new” form.
- 3) If necessary, you can add a cover letter with any information that was missing or incomplete in your original application. The cover letter may also include any updates to the information that was included in the original application.
- 4) Fax the “new” application and/or cover letter to Health Insurance British Columbia (HIBC) using the fax number on the application form.

## Field-by-Field Instructions

### Patient Information

The PharmaCare forms are in a “fill and print” PDF format.

Patient Name	Patient's name as shown on his or her CareCard.
Birth Date	Patient's full birth date (in <b>YYYY/MM/DD</b> format). <b>YYYY</b> = the year that the person was born; <b>MM</b> = the two digits for the month they were born (e.g., 01 = January); and <b>DD</b> = the two digits for the day they were born.
Personal Health (CareCard) Number	Patient's Personal Health Number from their CareCard.
Date of Application	Date you are completing the form in <b>YYYY/MM/DD</b> format.
Rx Attached	Check the appropriate box to indicate if a prescription (Rx) is being submitted with this application. <b>Note:</b> This assists in ensuring all the appropriate information is accounted for.

### Health Care Provider Information

Facility	Name of the prosthetic facility requesting the funding approval.
Pharmacy Equivalency Code	Your facility's 10-digit pharmacy equivalency code (PEC) (e.g., BC00000A01).
Facility Fax Number	Your facility's current fax number, where forms may be faxed back to once they have been reviewed.

### Service Information

Cause /Diagnosis	Indicate the cause or diagnosis that led to the amputation.
Current Device	Provide details of the last prosthesis or service that was supplied to the patient.
Date Supplied (YYYY/MM/DD)	Date that the last prosthesis or service was supplied to the patient (in <b>YYYY/MM/DD</b> format).
Referring Physician	The name of the Referring Physician. Ensure that the patient is still under the care of the physician who is listed on the form, or that the physician listed was responsible for prescribing the requested prosthesis or supplies.
List other Funding Agencies Involved	List all other funding agencies (i.e., Veterans Affairs Canada (VAC), Non-Insured Health Benefits (NIHB), or the Insurance Corporation of British Columbia (ICBC)), that are involved with funding services or prostheses for the patient. Include information on why this agency is not being requested to provide funding for this Request.  <b>Note:</b> This does not include funding from your patient's extended health or third-party insurers such as Pacific Blue Cross, Champs or War Amps.

### Rationale for Request

Include a relevant justification for the need for the prosthesis or supplies. Please be very specific about your choices by including any previous complications or problems that led to this decision/choice and any specific information about the prosthesis or patient.

Include details on which side is being fitted and/or any other amputations that the patient has had.

Was the replacement requested by a physician? If so, please include a physician prescription or note explaining why the prosthesis is required.

If the request is not the result of a physician request, please be specific as to why the request is being made.

Detailed responses are required. If insufficient detail is provided, the health care provider may receive a call for clarification or the application may be returned with a request for additional information.

A work order may be submitted in place of writing all the information on the form; however, if a work order is supplied, the work order number needs to be provided to assure that the appropriate information is reviewed.

**Note:** Additional information may be included in a cover letter, or as an attachment to the form.

Quantity	Quantity for each Product Identification Number (PIN).
Product Identification Number (PIN)	A list of Product Identification Numbers (PINs) is available from the PharmaCare website at <a href="http://www.health.gov.bc.ca/pharmacare/pins/prospins.html">www.health.gov.bc.ca/pharmacare/pins/prospins.html</a> . You may request approval for up to two separate PINs on each application.
Estimated Total	Enter the total estimated cost for each Product Identification Number (PIN) separately.

### *Patient/Agent Certification*

Only the patient should sign this form. An agent may sign on behalf of a patient who is a minor, or who is not capable of signing on their own. This is important because this signature certifies that the patient:

- understands that the health care provider is providing a service, supply or prosthesis to them, and that they are **not entitled to another prosthesis for at least three years**;
- understands that they are liable to the Minister of Finance for the cost of any benefits that PharmaCare paid on their behalf that they were not entitled to receive;
- accepts responsibility for any additional costs to the health care provider; and
- confirms that the information provided on this form is true and correct to the best of their knowledge.

### *Health Care Professional Certification*

This form is to be signed by the appropriate health care professional submitting the request. By signing, the health care professional confirms that:

- the information they have provided is true and correct, to the best of their knowledge; and
- they have explained the request to the patient.

### *PharmaCare Use Only*

This area will be completed by the Prosthetic and Orthotic Committee members and/or Health Insurance British Columbia (HIBC) staff. Please read it carefully. **No services should be provided until the application is approved** by PharmaCare. Any requests for additional information need to be forwarded to HIBC at your earliest convenience.

**Note:** The patient's PharmaCare Plan should be noted in the box labelled **PharmaCare Plan**. Coverage under various plans is subject to change without notice so always confirm the plan coverage with your patient **before** billing. If the plan is noted as N/R or N/Reg (Not Registered), the patient **must be registered** with Fair PharmaCare **before** receiving the prosthesis, supply, or service, in order to receive PharmaCare assistance.