BRITISH COLUMBIA | Health InsuranceBC

PHARMACARE MASTECTOMY BENEFITS

INVOICE

INVOICE # _____

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.

Completed forms should be submitted to HIBC: Fax: 250 405-3587 OR Mail to: PharmaCare, PO Box 9655 Stn Prov Govt, Victoria BC V8W 9P2

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)

DATE OF SURGERY (RIGHT) (YYYY / MM / DD)

DATE OF SURGERY (LEFT) (YYYY / MM / DD)

PROVIDER INFORMATION

PROVIDER OPERATING NAME

SITE ID B C

PROVIDER FAX NUMBER

DETAILED INFORMATION

REFERRING PHYSICIAN

MSP NUMBER

PIN	QTY	DETAILS	COST
		TOTAL	

DATE DISPENSED (YYYY / MM / DD)

PAYMENT TO CLIENT ☐

CLIENT CERTIFICATION

- I have read and understood the information being claimed for on this invoice.
- I agree the above goods and/or services were provided to me.
- 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 that I am responsible for any outstanding balance.
- I have been advised of PharmaCare's replacement policy. I understand that I will not be eligible for another mastectomy device for this purpose for at least 24 months, and then only upon demonstration that the existing device no longer meets my basic functionality needs.
- I certify that for my own protection, I am not signing a blank form and leaving it on-site for future use.

CLIENT SIGNATURE

CLIENT NAME (PRINT)

DATE SIGNED (YYYY / MM / DD)

PROVIDER CERTIFICATION

- I hereby certify that the above goods and/or services have been supplied to my client, on the dispense date above.
- I have explained the above goods and/or services to my client.

SIGNATURE OF HEALTH CARE PROVIDER

NAME OF HEALTH CARE PROVIDER (PRINT)

DATE SIGNED (YYYY / MM / DD)

PRINT RESET