BRITISH COLUMBIA | Health InsuranceBC

PHARMACARE OSTOMY 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)

REFERRING PHYSICIAN

MSP NUMBER

PROVIDER INFORMATION

PROVIDER OPERATING NAME

SITE ID

B C

PROVIDER FAX NUMBER

DETAILED INFORMATION

PIN	DAYS SUPPLY	QTY*	DETAILS	RETAIL COST
			TOTAL	

*Quantity given must specify units (e.g., g for creams, # items for wipes, pouches, etc.)

DATE DISPENSED (YYYY / MM / DD)

PAYMENT TO CLIENT ☐

CLIENT/AGENT 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 certify that I have undergone bladder or bowel surgery that has resulted in a colostomy, ileostomy, or urostomy, requiring an external pouch.
- I certify that for my own protection, I am not signing a blank form and leaving it on-site for future use.

CLIENT/AGENT SIGNATURE

CLIENT/AGENT NAME (PRINT)

DATE SIGNED (YYYY / MM / DD)

PHARMACIST/HEALTH CARE 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 and/or their agent.

SIGNATURE OF PHARMACIST OR HEALTH CARE PROVIDER

COLLEGE OF PHARMACISTS OF BC ID#
OR NAME OF HEALTH CARE PROVIDER (PRINT)

DATE SIGNED (YYYY / MM / DD)