BRITISH COLUMBIA | Ministry of Health

PHARMACARE

OFFLOADING ORTHOTIC BENEFITS APPLICATION FOR FINANCIAL ASSISTANCE

DATE OF APPLICATION (YYYY / MM / DD)

Submit completed forms to HIBC via Fax: 250 405-3590
OR Mail to: PharmaCare, PO Box 9655 Stn Prov Govt, Victoria BC V8W 9P2

CLIENT INFORMATION – ENTER LEGAL NAME AND 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 OR NURSE PRACTITIONER

HEALTH AUTHORITY OUTPATIENT/AMBULATORY CLINIC

CLINICIAN NAME

LIST OTHER FUNDING AGENCIES INVOLVED (E.G., NON-INSURED HEALTH BENEFITS, ICBC, ETC.)

DEVICE PROVIDER INFORMATION

PROVIDER OPERATING NAME

SITE ID

B C

PROVIDER FAX NUMBER

SERVICE INFORMATION

◯ INITIAL *(Requires referral)* ◯ REPLACEMENT ◯ REPAIR ◯ ADJUSTMENT

ATTACHMENTS

☐ OUTPATIENT CLINIC REFERRAL FORM

SIDE BEING FITTED

☐ RIGHT ☐ LEFT ☐ BILATERAL

CAUSE / DIAGNOSIS

CURRENT DEVICE (IF ANY)

DATE SUPPLIED (YYYY / MM / DD)

DETAILED RATIONALE FOR REQUEST – ATTACH ADDITIONAL PAGE IF MORE SPACE REQUIRED

DETAILED INFORMATION

DETAILS / PART # / QUANTITY	PHARMACARE PRICE	PROVIDER PRICE (IF DIFFERENT)

QTY	PIN	TOTAL PHARMACARE AMOUNT REQUESTED	PROVIDER TOTAL (IF DIFFERENT)

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, contact the Health Insurance BC (HIBC) Chief Privacy Officer at PO Box 9035 STN Prov Govt, Victoria BC V8W 9E3; or call 604 683-7151 (Vancouver) or 1 800 663-7100 (toll free).

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CLIENT LEGAL LAST NAME

PERSONAL HEALTH NUMBER (PHN)

DATE OF APPLICATION (YYYY / MM / DD)

PHARMACARE ELIGIBILITY PERSONAL INJURY

Client must complete this section for each application even if they were previously approved for PharmaCare coverage.
(Note: for your own protection, do not sign blank copies of forms and leave them with your provider for future use. PharmaCare may delay or deny payment to providers who ask their clients to sign blank forms. Clients may then be responsible for payment of the device.).

◯ Yes ◯ No	Do you need the device due to a condition (i.e., injury, illness or other) allegedly caused by another person's act or omission? (e.g., motor vehicle crash, accident, or assault) **If no, please complete the Client Certification section below. If yes, please answer the following:**
◯ Yes ◯ No	Do you have an approved PharmaCare form #5467/patient statement already on file? **If no, please complete and submit form #5467 to PharmaCare for review of your eligibility. If yes, please answer the following:**
◯ Yes ◯ No	Have the circumstances of the settlement or award changed since your last application? **If yes, please complete and submit form #5467 to PharmaCare for review of your eligibility and complete the Client Certification section below. If no, please complete the Client Certification section below.**

CLIENT/AGENT CERTIFICATION

Please read the following statements:

I have read and understood the information on this application.

I hereby certify that the information given in this application, and in any documents attached to or forming part of this application, is true and correct.

I understand that I am responsible for any outstanding balance if the cost of my device and/or service exceeds PharmaCare coverage. My provider has explained the billing to me.

I understand that if PharmaCare pays more costs than I was eligible for, I am obligated to repay the extra amount.

I have been advised of PharmaCare's replacement policy. I understand I will not be eligible for another orthotic device for this limb for **36 months** as outlined in the PharmaCare Policy Manual. Then **only** upon demonstration that the existing device no longer meets my basic functionality needs.

I understand that I must register for Fair PharmaCare before any device and/or service is dispensed to receive income-based Fair PharmaCare coverage. Without registration, my Fair PharmaCare deductible will be $10,000.00.

CLIENT/AGENT SIGNATURE

CLIENT/AGENT NAME (PRINT)

DATE SIGNED (YYYY / MM / DD)

ORTHOTIST 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 am the person responsible for assessing this client. Any services provided to the client by an Orthotics Prosthetics Canada (OPC) resident will have a supervisor on site and adhere to the Scope of Practice set out by OPC.
- I have explained the information on this application to my client and/or their agent.

ORTHOTIST SIGNATURE

ORTHOTIST NAME (PRINT)

CBCPO CERTIFICATION #

DATE SIGNED (YYYY / MM / DD)

PHARMACARE USE ONLY

AMOUNT APPROVED

PHARMACARE PLAN*

*(SUBJECT TO CHANGE WITHOUT NOTICE).

DATE REVIEWED

APPROVAL ENDS

DATE FAXED BACK

◯ REQUEST APPROVED ◯ MORE INFORMATION REQUIRED ◯ REQUEST NOT APPROVED

COMMENTS (IF ANY)

Save Print Clear Form