



Please read the Provider Enrollment Guide prior to completing this form. The Enrollment Guide will help you complete the form correctly and completely. Incomplete or inaccurate forms will be returned unprocessed.

1. SITE INFORMATION (all fields in this section are mandatory)

Form with fields: a. Operating Name, b. Site ID, c. Site Address, City, Prov, Postal Code, d. Mailing Address, e. Payment Remittance Address, Site Phone Number, Site Fax Number, f. Email Address, g. Site Manager Name, Registration ID, h. Proposed Opening Date

2. PROVIDER TYPE (Mandatory - must choose at least one Pharmacy or Device Class)

Form with sections: a. Pharmacy Class (Community, Out-Patient Hospital), b. Pharmacy Sub-class (Opioid Agonist, Plan B), c. Device Class (Devices), d. Device Sub-class (Compression Garment, Limb Prosthesis, Breast Prosthesis, Ocular Prosthesis, Orthosis, Insulin Pump, Other\*)

Pharmacies: Please include copy of College of Pharmacists of BC (CPBC) licence with application.

Non-Pharmacy Device Providers: Please include copy of business licence.

3. SUB-CLASS ELIGIBILITY

Please answer all of the following class-specific questions that apply to your site (as indicated in section 2 above).

IMPORTANT: If you answer No to any of the questions below, attach a written explanation as to why PharmaCare should consider enrolling you in this sub-class.

Form with 6 questions: 1. Opioid Agonist Treatment, 2. Compression Garment, 3. Limb Prosthesis, 4. Breast Prosthesis, 5. Ocular Prosthesis, 6. Orthosis. Each question has Yes/No checkboxes.

4. SOFTWARE VENDOR

If you use PharmaNet to submit claims, please indicate the type of software used.

Form with fields: Vendor Name, Version

**5. OWNER INFORMATION (all fields in this section are mandatory)**

a. Type of Ownership

- Sole Proprietorship    Partnership    Corporation    Health Authority    Other – specify:

b. Registered or Legal Name of Sole Proprietor, Partnership, Corporation or Health Authority

c. Mailing Address

City

Prov

Postal Code

Phone Number

Fax Number

Email Address

d. For business types other than sole proprietorship, please **check type below** and include the **relevant** information, as applicable:

*(If you are unsure of what constitutes relevant information, consult your legal counsel)*

- Partnership: Please provide the list of partners and contact information on **Schedule A: Owner Details**.
- B.C. incorporated corporations that are not publicly traded (including subsidiary corporations): Provide a copy of the BC Company Summary, the shareholder's register and any relevant provisions of any shareholder agreements with respect to the operation of the site.
- B.C. incorporated corporations that are publicly traded: Provide a copy of the BC Company Summary.
- Federally incorporated corporations that are not publicly traded: Provide the names and contact information of all officers and directors on **Schedule A: Owner Details** and provide the shareholder's register and any relevant provisions of any shareholder agreements with respect to the operation of the site.
- Federally incorporated corporations that are publicly traded: Provide the names and contact information of all officers and directors on **Schedule A: Owner Details**.
- All corporations: a copy of any powers of attorney in respect of the corporation (showing the names and contact information of all persons who may exercise a power of attorney).

**6. ADDITIONAL SITES**

Please identify any **owner** or the **manager** of this site who is currently an **owner** or **manager** of any other site.

Name (First/Last)	Name (First/Last)

Each **owner** or **manager** named above must complete **Schedule B: Additional Sites**.

Note: As defined in the **Enrollment Guide**, in the case of a corporation, **owner** includes the corporation, the directors, the officers and, in the case of a corporation that is not publicly traded, the shareholders. In the case of a subsidiary corporation that is not publicly traded and that has a parent corporation that is not publicly traded, **owner** includes the parent corporation and the directors, officers and shareholders of the parent corporation.

**7. ADDITIONAL INFORMATION (all questions in this section are mandatory)**

Please carefully review and answer the following questions.

Note: When a term appears in **bold italic**, it is a defined term and the meaning can be found in the **Definitions** section of the **Enrollment Guide**.

**IMPORTANT:** If you answer **Yes** to any of the questions below, please consult the **Enrollment Guide** and complete **Schedule C: Additional Information**.

**Pharmacies and Device Providers**

1. a. Is any **owner** or the **manager** of this site currently required to pay any monies to the B.C. government or a **public insurer** as a result of a **relevant audit** of any site?  Yes    No
- b. Is any entity (e.g., corporation, person) currently required to pay any monies to the B.C. government or a **public insurer** as a result of a **relevant audit** of any other site that was, *during the audit period*, owned or managed by any **owner** or the **manager** of this site?  Yes    No
2. a. Has any **owner** or the **manager** of this site ever been the subject of an order or a conviction for an **information or billing contravention**?  Yes    No
- b. Has any **owner** or the **manager** of this site ever been the **owner** or **manager** of any other site at the time that an **information or billing contravention** occurred for which an order or conviction was issued with respect to that other site?  Yes    No
3. a. Are the **billing privileges** of any **owner** or the **manager** of this site currently suspended?  Yes    No
- b. Is any **owner** or the **manager** of this site currently an **owner** or **manager** of any other site in respect of which a person's **billing privileges** are suspended?  Yes    No
4. a. Has any **owner** or the **manager** of this site ever had their **billing privileges** cancelled?  Yes    No
- b. Was any **owner** or the **manager** of this site the **owner** or **manager** of any other site at the time that an incident occurred in relation to that site resulting in the cancellation of **billing privileges** for that site?  Yes    No

**Pharmacies and Device Providers (continued)**

5. Has any **owner** or the **manager** of this site, within the past 6 years, had a judgment entered against them in a court proceeding related to commercial or business activities regarding the provision of drugs, devices, substances or related services at any site?  Yes  No
6. Has any **owner** or the **manager** of this site, within the past 6 years, been convicted of an offence prescribed in section 22 (1) of the Provider Regulation? (see also section 7, question 6, in **Enrollment Guide**)  Yes  No
7. Has any **owner** or the **manager** of this site ever had their enrollment in any class of PharmaCare provider cancelled?  Yes  No
8. Has any **owner** of this site been a director of a corporation that declared or was petitioned into bankruptcy within the past 6 years?  Yes  No

**Pharmacies**

9. Has any **owner** or the **manager** of this site ever had their pharmacy licence suspended or cancelled?   
 (Please answer both questions). Suspension:  Yes  No  
Cancellation:  Yes  No
10. Has any **owner** or the **manager** of this site ever had their registration as a pharmacist with a governing body of pharmacists suspended or cancelled? (Please answer both questions). Suspension:  Yes  No  
Cancellation:  Yes  No
11. Has any **owner** or the **manager** of this site ever had any limits or conditions imposed as a result of disciplinary actions taken by a governing body of pharmacists in relation to any site?  Yes  No

**Device Providers** (including pharmacies that selected "Device Class" in section 2)

12. Has any **owner** or the **manager** of this site ever had any limits, conditions or prohibitions imposed as a result of disciplinary actions taken by the Canadian Board for Certification of Prosthetists and Orthotists in relation to any site?  Yes  No

**8. SIGNATURE OF AUTHORIZED REPRESENTATIVE OF THE APPLICANT (Mandatory)**

If approved as a PharmaCare Provider, I undertake not to submit false or misleading claims information and acknowledge that doing so is an offence under the *Pharmaceutical Services Act* and its related regulations.

Applicant Signature	Name (First, Last)	Date Signed
	Title	Phone Number

**9. MINISTRY APPROVAL (for PharmaCare use only)**

Signature	Name (First/Last) and Title
Date Signed	
Level of PharmaNet access granted <input type="checkbox"/> Full Access <input type="checkbox"/> DIS-only <input type="checkbox"/> None	

Provider Type

Enroll as requested      **OR**       Enroll as specified:
 

- Pharmacy
- Methadone Maintenance Pharmacy
- Plan B Pharmacy
- Devices
  - Compression Garment Provider
  - Limb Prosthesis Provider
  - Breast Prosthesis Provider
  - Ocular Prosthesis Provider
  - Orthosis Provider
  - Insulin Pump Manufacturer / Distributor
  - Other (ostomy supplies, diabetes supplies)

Do not enroll

Submit this form and accompanying documents by mail or fax. If submitting by fax, ensure transmission is legible.

Mail to: PharmaCare Information Support      Fax to: 250 405-3599  
 Health Insurance BC  
 PO Box 9684, STN PROV GOVT  
 Victoria BC V8W 9P7

Please note that the information requested on this form is collected by the Ministry of Health under Section 22 (1)(b) of the *Pharmaceutical Services Act* and will be used to determine eligibility for enrollment as a provider in the PharmaCare Program. If you have any questions about the collection of this personal information, please call Health Insurance BC and ask to speak to the Chief Privacy Officer. From the lower mainland: 604-683-7151, elsewhere in B.C. (toll-free): 1-800-663-7100.