BRITISH COLUMBIA | Ministry of Health

PHARMACARE PROVIDER CHANGE

to report any change to your PharmaCare enrollment information

As a PharmaCare provider, you are obligated to notify PharmaCare of certain changes as identified in the Provider Regulation. **Failure to abide by your duties and obligations may result in delay or suspension of payments.** *You may wish to consult with your legal counsel while preparing this form and associated documentation.*

Please check the appropriate change type(s) below. Submit the relevant Parts of the form, any required documentation, and this page, *signed* and *dated*. Incomplete or inaccurate forms will be returned unprocessed.

TYPE OF CHANGE

Check the applicable box(es) below to indicate the type of change(s). *Must check at least one.*

- ☐ Part A – Change in Provider Contact Information
- ☐ Part B – Change in Operating/Business or Corporate Name
- ☐ Part C – Change in Owner Information
- ☐ Part D – Change of Manager
- ☐ Part E – Change of Location
- ☐ Part F – Changes to a Power of Attorney
- ☐ Part G – Separate Submission of Supporting Documentation (required if you selected Part B through Part F)
- ☐ Part H – Cancellation of Sub-class
- ☐ Part I – Request to Add Sub-class
- ☐ Part J – Notice of Certain Actions or Events (as described in Part J of this form)
- ☐ Part K – Notice of Disposition or Closure

SUBMISSION INSTRUCTIONS

Include this cover page (signed) with the relevant parts of this form.

Scenario	Submit
For one or more changes that affect one site only	• relevant part (or parts) of the form (Part A to K as you have indicated above) • this cover page (signed), identifying the site affected by the change
For multiple sites for which you are making one or more changes that affect all those sites	• the relevant part (or parts) of the form (Part A to K as you have indicated above) • one copy of this cover page (signed), with all sites affected by that change listed below
For multiple sites for which you are making changes that affect some, but not all, of those sites	For each group of sites affected by a particular change: • the relevant part (or parts) of the form (Part A to K as you have indicated above) • one copy of this cover page (signed), with all sites affected by that change listed below
For changes B through F	Initially: • the relevant part (or parts) of the form (Part B to F as you have indicated above) • one copy of this cover page (signed) Subsequently: • Part G with the supporting documentation within the required timeline • one copy of this cover page (signed)

SITES AFFECTED BY CHANGE

Operating Name (as it appears on the PharmaCare Provider Enrollment Form)	Site ID

SIGNATURE OF AUTHORIZED REPRESENTATIVE OF THE 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.

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

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.

PART A – CHANGE IN PROVIDER CONTACT INFORMATION

Advance Notification Requirement: minimum 7 days before change

SITE INFORMATION

Operating Name – as it appears on PharmaCare Provider Enrollment Form	Site ID

INSTRUCTIONS: If you are relocating your site, please complete only **Part E – Change of Location**.

CONTACT INFORMATION

Current Contact Information

Current Site Mailing Address (if different from site address)	City	Prov	Postal Code
Current Payment Remittance Address (if different from site address)	City	Prov	Postal Code
Current Mailing Address of Owner	City	Prov	Postal Code

Current Phone Number	Current Fax Number	Current Email Address

New Contact Information – enter ONLY the information that is changing

New Site Mailing Address (if different from site address)	City	Prov	Postal Code
New Payment Remittance Address (if different from site address)	City	Prov	Postal Code
New Mailing Address of Owner	City	Prov	Postal Code

New Phone Number	New Fax Number	New Email Address

EFFECTIVE DATE *(must match supporting documentation and/or College of Pharmacists of BC records)*

PART B – CHANGE IN OPERATING/BUSINESS OR CORPORATE NAME

Advance Notification Requirement: minimum 7 days before change

SITE INFORMATION

Operating Name – as it appears on PharmaCare Provider Enrollment Form	Site ID

DOCUMENTATION REQUIREMENTS: For a change in operating/business name, submit a copy of your new pharmacy/business licence within 14 days of issuance, along with Part G of this form.

CHANGE INFORMATION

Indicate the type of change

- ☐ Operating/Business Name (e.g., name shown on pharmacy/business licence)
- ☐ Corporate Name (e.g., registered or legal name of sole proprietorship, partnership or corporation)

Name Change

Current Name
New Name

EFFECTIVE DATE *(must match supporting documentation and/or College of Pharmacists of BC records)*

PART C – CHANGE IN OWNER INFORMATION

Advance Notification Requirement: minimum 7 days before change

SITE INFORMATION

Operating Name – as it appears on PharmaCare Provider Enrollment Form		Site ID	
Site Address	City	Prov	Postal Code

INSTRUCTIONS:

Important: Do **not** complete this part of the form for a site that is being sold/undergoing a change in partnership. For the sale of a site (including partnership changes) the:

- current owner must complete Part K of this form, and
- new owner must apply for enrollment using the PharmaCare Provider Enrollment form (HLTH 5432): www.gov.bc.ca/health/forms/5432fil.pdf

1. In the **Owner Information** column, indicate your ownership type. Please check only one.
2. Provide any documents required (as indicated in the **Required Documentation** column).
3. Indicate the **Effective Date**.
4. Fill out **Details of Changes** section, providing information regarding officers, directors, shareholders (as applicable).
5. For each new owner, answer **all** questions in the **Additional Information** section.

NEW OWNER INFORMATION

Owner Information	Required Documentation
☐ B.C. incorporated corporations that are not publicly traded (including subsidiary corporations)*	• Names of **departing** officers, directors and shareholders • Names and contact information of all **new** officers, directors and shareholders You must also provide, using Part G of this form, a copy of the following **no later than 30 days** after the change: • New BC Company Summary (if applicable) • New shareholder's register (if applicable) • Relevant provisions of any new shareholder agreements with respect to the operation of any enrolled site (if applicable)
☐ B.C. incorporated corporations that are publicly traded*	• Names of **departing** officers and directors • Names and contact information of all **new** officers and directors You must also provide, using Part G of this form, a copy of the following **no later than 30 days** after the change: • New BC Company Summary
☐ Federally incorporated corporations that are not publicly traded*	• Names of all **departing** officers, directors and shareholders • Names and contact information of all **new** officers, directors and shareholders You must also provide, using Part G of this form, a copy of the following no **later than 30 days** after the change: • New shareholder's register (if applicable) • Relevant provisions of any new shareholder agreements with respect to the operation of any enrolled site (if applicable)
☐ Federally incorporated corporations that are publicly traded*	• Names of **departing** officers and directors • Names and contact information of all **new** officers and directors

EFFECTIVE DATE *(must match supporting documentation and/or College of Pharmacists of BC records)*

NOTE:** For a subsidiary corporation that is ***not publicly traded and that has a parent corporation that is ***not*** publicly traded, you must also provide information about any changes of officers, directors, or shareholders in the parent corporation.

This information is not required if either the subsidiary corporation or the parent corporation ***is*** publicly traded. In those cases, the Ministry of Health has waived the requirement to provide this information.

PART C – CHANGE IN OWNER INFORMATION continued

DETAILS OF CHANGES

Name of all DEPARTING officers, directors, shareholders (as applicable)

Name (First, Last)	Position

Names and contact information of all NEW officers, directors, shareholders (as applicable)

Name (First, Last)		Position		
Address		City	Prov	Postal Code
Phone Number	Fax Number	Email Address		
Name (First, Last)		Position		
Address		City	Prov	Postal Code
Phone Number	Fax Number	Email Address		
Name (First, Last)		Position		
Address		City	Prov	Postal Code
Phone Number	Fax Number	Email Address		
Name (First, Last)		Position		
Address		City	Prov	Postal Code
Phone Number	Fax Number	Email Address		
Name (First, Last)		Position		
Address		City	Prov	Postal Code
Phone Number	Fax Number	Email Address		
Name (First, Last)		Position		
Address		City	Prov	Postal Code
Phone Number	Fax Number	Email Address		

PART C – CHANGE IN OWNER INFORMATION continued

Names and contact information of all NEW officers, directors, shareholders (as applicable) continued				
Name (First, Last)		Position		
Address		City	Prov	Postal Code
Phone Number	Fax Number	Email Address		
Name (First, Last)		Position		
Address		City	Prov	Postal Code
Phone Number	Fax Number	Email Address		
Name (First, Last)		Position		
Address		City	Prov	Postal Code
Phone Number	Fax Number	Email Address		
Name (First, Last)		Position		
Address		City	Prov	Postal Code
Phone Number	Fax Number	Email Address		

ADDITIONAL INFORMATION

Please carefully review and answer the following questions for your provider type only.

If you answer **Yes** to any of the questions below, you must provide the details as stated in Section 7 of the Enrollment Guide (available at www.gov.bc.ca/pharmacarepharmacists) and complete the Details of Additional Information section below.

Pharmacies and Device Providers

1. a. Is any new ***owner*** 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 new ***owner*** of this site ever been the subject of an order or a conviction for an ***information or billing contravention***? ☐ Yes ☐ No
   b. Has any new ***owner*** 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 new ***owner*** of this site currently suspended? ☐ Yes ☐ No
   b. Is any new ***owner*** 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 new ***owner*** of this site ever had their ***billing privileges*** cancelled? ☐ Yes ☐ No
   b. Was any new ***owner*** 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
5. Has any new ***owner*** 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 new ***owner*** 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 new ***owner*** of this site ever had their enrollment in any class of PharmaCare provider cancelled? ☐ Yes ☐ No
8. Has any new ***owner*** of this site been a director of a corporation that declared or was petitioned into bankruptcy within the past 6 years? ☐ Yes ☐ No

PART C – CHANGE IN OWNER INFORMATION continued

Pharmacies

9. Has any new ***owner*** of this site ever had their pharmacy licence suspended or cancelled? *(Please answer both questions)*
   Suspension: ☐ Yes ☐ No
   Cancellation: ☐ Yes ☐ No

10. Has any new ***owner*** 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 new ***owner*** 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 are enrolled as Device Providers)

12. Has any new ***owner*** 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

If you answered **Yes** to any of the questions above, you must provide the details as stated in Section 7 of the Enrollment Guide (available at www.gov.bc.ca/pharmacarepharmacists) and complete the Details of Additional Information section below.

DETAILS OF ADDITIONAL INFORMATION

Identify the question number to which the details below pertain. Make a copy of this page if you need more space.

Question Number	Details

PART D – CHANGE OF MANAGER

Advance Notification Requirement: minimum 7 days before change

SITE INFORMATION

Operating Name – as it appears on PharmaCare Provider Enrollment Form		Site ID	
Site Address	City	Prov	Postal Code

INSTRUCTIONS: 1. Complete all fields.
2. Answer all relevant questions in the **Additional Information** section.

Note: Question 8 from the PharmaCare Enrollment Form, regarding bankruptcy of a corporation, is not relevant to new managers, and therefore is not listed in this section.

DOCUMENTATION REQUIRED:

For a change in pharmacy manager **only**, submit a copy of your new pharmacy licence **within 14 days of issuance**, along with Part G of this form.

MANAGER INFORMATION

Name of Current Manager – must match registration ID	Registration ID (if pharmacist – 5 digits)
Name of New Manager – must match registration ID - **mandatory**	Registration ID (if pharmacist – 5 digits)

EFFECTIVE DATE *(must match supporting documentation and/or College of Pharmacists of BC records)*

ADDITIONAL INFORMATION

Please carefully review and answer the following questions.

If you answer **Yes** to any of the questions below, you must provide the details as stated in Section 7 of the Enrollment Guide (available at www.gov.bc.ca/pharmacarepharmacists) and complete the Details of Additional Information section on the next page.

Pharmacies and Device Providers

1. a. Is the new ***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 the new ***manager*** of this site? ☐ Yes ☐ No
2. a. Has the new ***manager*** of this site ever been the subject of an order or a conviction for an ***information or billing contravention***? ☐ Yes ☐ No
   b. Has the new ***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 the new ***manager*** of this site currently suspended? ☐ Yes ☐ No
   b. Is the new ***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 the new ***manager*** of this site ever had their ***billing privileges*** cancelled? ☐ Yes ☐ No
   b. Was the new ***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
5. Has the new ***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 the new ***manager*** of this site, within the past 6 years, been convicted of an offence prescribed in section 22 (1) of the Provider Regulation? ☐ Yes ☐ No
7. Has the new ***manager*** of this site ever had their enrollment in any class of PharmaCare provider cancelled? ☐ Yes ☐ No

Pharmacies

9. Has the new ***manager*** of this site ever had their pharmacy licence suspended or cancelled? (Please answer both questions) Suspension: ☐ Yes ☐ No Cancellation: ☐ Yes ☐ No
10. Has the new ***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 the new ***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 the new ***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

PART D – CHANGE OF MANAGER continued

If you answered **Yes** to any of the preceding questions, you must provide the details as stated in Section 7 of the Enrollment Guide (available at www.gov.bc.ca/pharmacarepharmacists) and complete the Details of Additional Information section below.

DETAILS OF ADDITIONAL INFORMATION

Identify the question number to which the details below pertain. Make a copy of this page if you need more space.

Question Number	Details

PART E – CHANGE OF LOCATION

Advance Notification Requirement: minimum 7 days before change

SITE INFORMATION

Operating Name – as it appears on PharmaCare Provider Enrollment Form	Site ID

DOCUMENTATION REQUIRED:

Using Part G of the form, provide a copy of your new pharmacy/business licence **within 14 days** of date of issuance.

LOCATION INFORMATION

Current Location

Current Address		City	Prov	Postal Code
Current Phone Number	**Current Fax Number**	**Current Email Address**		

New Location – Enter ONLY the information that is changing

New Address		City	Prov	Postal Code
New Mailing Address (if different from site address)		City	Prov	Postal Code
New Payment Remittance Address (if different from site address)		City	Prov	Postal Code
New Phone Number	New Fax Number	New Email Address		

EFFECTIVE DATE *(must match supporting documentation and/or College of Pharmacists of BC records)*

PART F – CHANGES TO A POWER OF ATTORNEY

Advance Notification Requirement: minimum 7 days before change

SITE INFORMATION

Operating Name – as it appears on PharmaCare Provider Enrollment Form	Site ID

DOCUMENTATION REQUIRED:

No more than 30 days after the change in Power of Attorney takes effect, using Part G of this form, you must provide a copy of any new corporate Powers of Attorney showing the names and contact information of anyone who may exercise a power of attorney in respect to the corporation.

DETAILS OF CHANGES

Name of all those who NO LONGER have Power of Attorney

Name (First, Last)	Position

Names and contact information for NEW Power(s) of Attorney

Name (First, Last)		Position		
Address		City	Prov	Postal Code
Phone Number	Fax Number	Email Address		
Name (First, Last)		Position		
Address		City	Prov	Postal Code
Phone Number	Fax Number	Email Address		
Name (First, Last)		Position		
Address		City	Prov	Postal Code
Phone Number	Fax Number	Email Address		
Name (First, Last)		Position		
Address		City	Prov	Postal Code
Phone Number	Fax Number	Email Address		
Name (First, Last)		Position		
Address		City	Prov	Postal Code
Phone Number	Fax Number	Email Address		

EFFECTIVE DATE *(must match supporting documentation and/or College of Pharmacists of BC records)*

PART G – SEPARATE SUBMISSION OF SUPPORTING DOCUMENTATION

SITE INFORMATION	
Operating Name – as it appears on PharmaCare Provider Enrollment Form	Site ID

INSTRUCTIONS:

Complete and submit Part G with the required documentation if you have recently notified PharmaCare of a change on Parts B through F. Indicate the change you reported and the required documentation you are now submitting. *Ensure dates on licenses or other supporting documentation match "Effective Date" fields.*

CHANGE INFORMATION	
Change Reported	**Required Documentation Attached**
☐ **Part B - Change in Operating/Business or Corporate Name** Submission deadline: **within 14 days** of issuance	☐ Pharmacy licence (for pharmacy providers) **OR** ☐ Business licence (for device providers)
☐ **Part C - Change in Owner Information** Submission deadline: **no later than 30 days** after the change	You may wish to refer to Part C for details of documentation requirements. ☐ New BC Company Summary ☐ New shareholder's register ☐ Relevant provisions of any new shareholder agreements with respect to the operation of any enrolled site ☐ Next Annual Report filed, for confirmation of changes (may be submitted when ready) - applies to non-publicly traded B.C. Corporations.
☐ **Part D - Change of Manager (Pharmacy only)** Submission deadline: **within 14 days** of issuance	☐ Pharmacy licence
☐ **Part E - Change of Location** Submission deadline: **within 14 days** of issuance	☐ Pharmacy licence (for pharmacy providers) **OR** ☐ Business licence (for device providers)
☐ **Part F - Changes to a Power of Attorney** Submission deadline: **no later than 30 days** after the change in Power of Attorney taking effect.	You may wish to refer to Part F for details of documentation requirements. ☐ Copy of any new corporate Powers of Attorney

PART H – CANCELLATION OF SUB-CLASS

Advance Notification Requirement:
- **Methadone — 30 days before services will end**
- **Plan B — No later than the last day of the month before the final full month in which service will be provided**
- **Device Provider — as soon as reasonably practicable**

SITE INFORMATION

Operating Name – as it appears on PharmaCare Provider Enrollment Form	Site ID

SUB-CLASS TO BE CANCELLED

Pharmacy Sub-class

- ☐ Opioid Agonist Treatment Provider
- ☐ Plan B Pharmacy

Device Sub-class

- ☐ Compression Garment Provider
- ☐ Limb Prosthesis Provider
- ☐ Breast Prosthesis Provider
- ☐ Ocular Prosthesis Provider
- ☐ Orthosis Provider
- ☐ Insulin Pump Manufacturer/Distributor
- ☐ Other (ostomy supplies, diabetes supplies)

EFFECTIVE DATE

PART I – REQUEST TO ADD SUB-CLASS

SITE INFORMATION

Operating Name – as it appears on PharmaCare Provider Enrollment Form	Site ID

INSTRUCTIONS:

Please submit requests **at least 21 days in advance** of requested effective date to allow for processing.
Requests will be reviewed as soon as possible. The Ministry of Health will notify you by mail of the decision.
Note: Your site can submit claims to PharmaCare under a new sub-class **only** after your enrollment in the sub-class has been confirmed.

SUB-CLASSES REQUESTED

Pharmacy Sub-class	Device Sub-class		
☐ Opioid Agonist Treatment Provider	☐ Compression Garment Provider	☐ Ocular Prosthesis Provider	☐ Insulin Pump Manufacturer/Distributor
☐ Plan B Pharmacy	☐ Limb Prosthesis Provider	☐ Orthosis Provider	☐ Other (ostomy supplies, diabetes supplies)
	☐ Breast Prosthesis Provider		

SUB-CLASS ADDITIONAL INFORMATION

Answer only the following questions if they apply to sub-classes selected above.

IMPORTANT: For each question to which you answer **No**, **attach a written explanation** as to why PharmaCare should consider enrolling you in this sub-class.

1. **Opioid Agonist Treatment**
   Have all the pharmacists providing any services at your pharmacy successfully completed the relevant training for the provision of methadone maintenance services? *(please see Enrollment Guide for training requirements)* ☐ Yes ☐ No
2. **Compression Garment**
   Are compression garments being fitted only by persons who have completed training by a manufacturer of compression garments in fitting the type of compression garment being fitted? ☐ Yes ☐ No
3. **Limb Prosthesis**
   Are limb prostheses being provided only by persons recognized by the Canadian Board for Certification of Prosthetists and Orthotists as qualified to fit limb prostheses? ☐ Yes ☐ No
4. **Breast Prosthesis**
   Are breast prostheses being fitted only by persons who have completed training by a breast prosthesis manufacturer in fitting breast prostheses? ☐ Yes ☐ No
5. **Ocular Prosthesis**
   Are ocular prostheses being provided only by persons recognized by the National Examining Board of Ocularists as qualified to fit ocular prostheses? ☐ Yes ☐ No
6. **Orthosis**
   Are orthoses being provided only by persons recognized by the Canadian Board for Certification of Prosthetists and Orthotists as qualified to fit orthoses? ☐ Yes ☐ No

REQUESTED EFFECTIVE DATE

MINISTRY APPROVAL (FOR PHARMACARE USE ONLY)

Signature	Name (First/Last) and Title
Date Signed	

Current Enrollment Status	New Sub-Class Approved	
☐ Pharmacy	☐ None	☐ Pharmacy
☐ Opioid Agonist Treatment Provider		☐ Opioid Agonist Treatment Provider
☐ Plan B Pharmacy		☐ Plan B Pharmacy
☐ Devices		☐ Devices
☐ Compression Garment Provider		☐ Compression Garment Provider
☐ Limb Prosthesis Provider		☐ Limb Prosthesis Provider
☐ Breast Prosthesis Provider		☐ Breast Prosthesis Provider
☐ Ocular Prosthesis Provider		☐ Ocular Prosthesis Provider
☐ Orthosis Provider		☐ Orthosis Provider
☐ Insulin Pump Manufacturer / Distributor		☐ Insulin Pump Manufacturer / Distributor
☐ Other (ostomy supplies, diabetes supplies)		☐ Other (ostomy supplies, diabetes supplies)

PART J – NOTICE OF CERTAIN ACTIONS OR EVENTS

SITE INFORMATION

Operating Name – as it appears on PharmaCare Provider Enrollment Form	Site ID

INSTRUCTIONS:

Inform us only of the relevant new action or event.

NOTIFICATION REQUIREMENT:

You must inform PharmaCare **immediately** of any of the following events subsequent to enrollment:

- order, suspension and/or cancellation of billing privileges, judgment or conviction
- suspension or cancellation of pharmacist's registration and/or pharmacy licence
- disciplinary action taken by a governing body or action or proceeding taken by the Canadian Board for Certification of Prosthetists and Orthotists
- instances in which an ***owner*** of the site has been the director of a corporation that has declared or been petitioned into bankruptcy
- a requirement to pay an amount to a public insurer, other than BC PharmaCare

STATEMENTS

Please carefully review the following statements and check any that apply to you.
For any of the following statements you select below, fill out the Additional Information table on the next page.

Pharmacies and Device Providers

1. ☐ a. An ***owner*** or the ***manager*** of this site is currently required to pay any monies to a ***public insurer*** as a result of a ***relevant audit*** of any site.
   ☐ b. An entity (e.g., corporation, person) is currently required to pay monies to a ***public insurer*** as a result of a ***relevant audit*** of any other site that was, *during the audit period*, owned or managed by an ***owner*** or the ***manager*** of this site.
2. ☐ a. An ***owner*** or the ***manager*** of this site is the subject of an order or a conviction for an ***information or billing contravention***.
   ☐ b. An ***owner*** or the ***manager*** of this site is the ***owner*** or ***manager*** of another site for which an order or conviction for an ***information or billing contravention*** has been issued.
3. ☐ a. The ***billing privileges*** of an ***owner*** or the ***manager*** of this site are currently suspended.
   ☐ b. An ***owner*** or the ***manager*** of this site currently an ***owner*** or ***manager*** of another site in respect of which a person's ***billing privileges*** are suspended.
4. ☐ a. An ***owner*** or the ***manager*** of this site has had their ***billing privileges*** cancelled.
   ☐ b. An ***owner*** or the ***manager*** of this site was the ***owner*** or ***manager*** of another site at the time that an incident occurred in relation to that site resulting in the cancellation of ***billing privileges*** for that site.
5. ☐ An ***owner*** or the ***manager*** of this site, within the past 6 years, has 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.
6. ☐ An ***owner*** or the ***manager*** of this site, within the past 6 years, has been convicted of an offence prescribed in section 22 (1) of the Provider Regulation (see also section 7, question 6, in **Enrollment Guide**).
7. ☐ An ***owner*** or the ***manager*** of this site has ever had their enrollment in any class of PharmaCare provider cancelled.
8. ☐ An ***owner*** of this site has been a director of a corporation that declared or was petitioned into bankruptcy within the past 6 years.

Pharmacies

9. ☐ An ***owner*** or the ***manager*** of this site has had their pharmacy licence suspended or cancelled. ☐ Suspension ☐ Cancellation *(If 9 is checked, you must check at least 1).*
10. ☐ An ***owner*** or the ***manager*** of this site has had their registration as a pharmacist with a governing body of pharmacists suspended or cancelled. ☐ Suspension ☐ Cancellation *(If 10 is checked, you must check at least 1).*
11. ☐ An ***owner*** or the ***manager*** of this site has had limits or conditions imposed as a result of disciplinary actions taken by a governing body of pharmacists in relation to any site.

Device Providers (including pharmacies that that are enrolled as Device Providers)

12. ☐ An ***owner*** or the ***manager*** of this site has had 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.

PART J – NOTICE OF CERTAIN ACTIONS OR EVENTS continued

If you checked any of the preceding statements in Part J, you must provide the details.

ADDITIONAL INFORMATION

Identify the statement number to which the details pertain. Make a copy of this page if you need more space.

Statement Number	Details

PART K – NOTICE OF DISPOSITION OR CLOSURE

Advance Notification Requirement: minimum 30 days before change

SITE INFORMATION

Operating Name – as it appears on PharmaCare Provider Enrollment Form	Site ID

PLEASE NOTE: Health Insurance BC may contact you to schedule removal of any PharmaCare-installed equipment and cabling.

TYPE OF CHANGE AND EFFECTIVE DATE

☐ Disposition (e.g., sale of site) ☐ Closure	Effective Date

DETAILED SITE INFORMATION

Site Address	City	Prov	Postal Code

Site Phone Number	Manager Name	Manager's Phone Number (after closure)

Contact Name for Building Access	Contact Phone Number for Building Access

Building Will Be

☐ Re-occupied ☐ Demolished

FOR DISPOSITION ONLY: CONTACT INFORMATION

Current Owner

Name (First, Last)	Position		
Address	**City**	**Prov**	**Postal Code**

Phone Number	Fax Number	Email Address

New Owner

Name (First, Last)	Position		
Address	**City**	**Prov**	**Postal Code**

Phone Number	Fax Number	Email Address

FOR HIBC USE ONLY

Equipment Removal Required? ☐ Yes ☐ No	iStore Order Number	PharmaNet de-activated on

If you have questions about PharmaCare/PharmaNet equipment, please contact HIBC Information Support by:

- Calling the HelpDesk and asking for Information Support or
- Sending an email to: informationsupport@hibc.gov.bc.ca

PRINT

CLEAR FORM