

PharmaCare Provider Enrollment Guide

*A step-by-step guide to submitting
your enrollment application*



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UNDERSTANDING PHARMACARE ENROLLMENT

On May 31, 2012, the **Pharmaceutical Services Act** (www.bclaws.ca/civix/document/id/complete/statreg/12022_01) came into effect. Under section 11(2) of the Act, pharmacies, facilities or other places where drugs, devices, substances or related services are provided may apply for enrollment with the PharmaCare program.

The **Provider Regulation**, which came into effect on December 1, 2014, sets out the prescribed criteria for enrollment and the ongoing responsibilities of PharmaCare providers. The Regulation is available on the Pharmacies and Medical Suppliers Web page at www.bclaws.ca/civix/document/id/complete/statreg/222_2014. Please bookmark or print the Regulation for your ongoing reference.

ABOUT THIS GUIDE/GENERAL INSTRUCTIONS

This guide gives step-by-step instructions on how to enroll as a PharmaCare provider. Online versions of this guide and the forms are available at www.gov.bc.ca/pharmacarepharmacists or www.gov.bc.ca/pharmacaredeviceproviders.

- Please PRINT clearly when completing the forms. You may also complete the forms online and print them.
- Do not submit your enrollment form more than 3 months before your site's projected opening date.
- Fill out all sections that apply at the time of enrollment.

Important: If information on your enrollment form changes before your enrollment is approved, you must resubmit the form. If your information changes after approval, submit a Provider Change Form (HLTH 5433). Please see Notification Requirements on page 16 for more information on required notifications of changes.

- Any time a word appears in **bold italic** on the form—or in this guide—it is a defined term and the meaning can be found in the **Definitions** section.
- Words that appear in **bold orange** refer to the field of same name on the [PharmaCare Provider Enrollment Form \(HLTH 5432\)](#) and the PharmaCare Provider Change Form (HLTH 5433).
- We recommend that you print a copy of the Provider Regulation to refer to while reading this guide and completing the form.
- If completing the form online, please upgrade to the latest (free) version of Adobe Acrobat Reader from <http://get.adobe.com/reader/>. Only Acrobat Reader 11 allows you to download and then save a partially completed form.

IMPORTANT: Providing false or inaccurate information in the enrollment process is a serious matter. You may wish to seek legal advice on completing the form(s).

WHO SHOULD ENROLL?

The application should be completed by any site wishing to enroll as a provider with PharmaCare in order for:

- the site to receive **payment** for providing PharmaCare benefits to PharmaCare-eligible individuals, and/or
- PharmaCare-eligible individuals to receive **payment** for PharmaCare benefits provided by their site.

DEFINITIONS

TERM	DEFINITION
Billing privileges	The privilege of seeking payment from PharmaCare or another <i>public insurer</i> for providing benefits
Information or billing contravention	Contravention of a <i>pharmacy enactment</i> or any legislation equivalent to a pharmacy enactment in another Canadian jurisdiction or a requirement of a <i>public drug insurance program</i> related to: <ul style="list-style-type: none">• providing false, incomplete or misleading information (e.g., submitting false claims)• not providing required information• obstructing a person exercising a power or duty (e.g., an auditor)• anything that resulted in suspension or cancellation of <i>billing privileges</i>• contravention of a <i>pharmacy enactment</i>, the E-Health Act, the Freedom of Information and Protection of Privacy Act, the Personal Information Protection Act, the Health Professions Act or regulation made under them related to the collection, use and disclosure of personal information
Manager	As declared on the first page of the PharmaCare Enrollment Form (section 1e): <ul style="list-style-type: none">• For pharmacies, the manager as defined in the Pharmacy Operations and Drug Scheduling Act• For other provider types, the manager of the site
Owner	<ul style="list-style-type: none">• A sole proprietor• A partner• In the case of a publicly traded corporation, including a publicly traded subsidiary corporation:<ul style="list-style-type: none">▪ The corporation▪ The officers and directors• In the case of a corporation that is not publicly traded, including a subsidiary corporation:<ul style="list-style-type: none">▪ The corporation▪ The officers, directors and shareholders

TERM	DEFINITION
	<ul style="list-style-type: none"> ▪ In the case of a subsidiary corporation that is not publicly traded and which has a parent corporation that is not publicly traded, the officers, directors and shareholders of the parent corporation
Pharmacy enactment	The Pharmaceutical Services Act , Continuing Care Act , Medicare Protection Act , Pharmacy Operations and Drug Scheduling Act , Pharmacists, Pharmacy Operations and Drug Scheduling Act , or any regulation made under these acts
Provider	An entity that is enrolled in PharmaCare for the purpose of receiving payment
Public drug insurance program	The First Nations Health Authority program, the Non-Insured Health Benefits (NIHB) program or a drug and/or medical device program of a provincial or territorial government of Canada other than B.C. (e.g., Ontario Drug Benefit Program)
Public insurer	The First Nations Health Authority, the Government of Canada or a provincial or territorial government of Canada
Relevant audit	<p>An audit conducted under a <i>pharmacy enactment</i> or by a <i>public insurer</i> in relation to the insurer's <i>public drug insurance program</i></p> <p>For example, <i>relevant audit</i> includes audits conducted by PharmaCare and NIHB but not audits conducted by municipal governments or the Canada Revenue Agency.</p>
Site ID	The unique identification code issued to the site by Health Insurance BC (e.g., A01), also known as the Pharmacy Code or PharmaCare Code/ID

FORM INSTRUCTIONS

1. SITE INFORMATION

FIELD ID	FIELD NAME	INSTRUCTIONS
a	Operating Name	<p>The name of the site for which the applicant is seeking enrollment</p> <p><i>Note: Pharmacies should provide the Operating Name as shown on their pharmacy licence; device providers should use the Operating Name as shown on their business licence. A copy of either the pharmacy licence or the business licence, as appropriate, must be submitted with the PharmaCare enrollment form.</i></p>
b	Site ID	<p>The unique identification code issued to the site by Health Insurance BC (e.g., A01), also known as the Pharmacy Code or PharmaCare Code/ID</p>
c	Site Address	<p>The street address of the physical location where drugs, devices, substances or related services will be provided. This must be a street address, not a box number (e.g., 123 Main Street not P.O. Box 1234) May not include a P.O. Box number (A P.O. Box number may be included in the mailing address – see (d) below)</p>
d	Mailing Address	<p>The address where the applicant wishes to receive correspondence (required only if different from the Site Address).</p> <p>Can be a P.O. Box number.</p>
e	Payment Remittance Address	<p>The address to which the applicant wishes payment advices to be sent (Required only if different from the Site Address). Can be a P.O. Box number.</p>
f	Email Address	<p>The email address at which you wish to be contacted about this application (e.g., email address of the site or of the manager)</p>
g	Manager Name/ Registration ID	<p>Full name of the current manager of the site</p> <p>Pharmacies: Enter the name of the pharmacy manager as it appears on their pharmacist licence and their College of Pharmacists of BC Registration ID (the 5-digit number, which may have a leading 0).</p> <p>Device providers: Leave the Registration ID field blank. Do not enter “TBD”/ “To be determined”</p>
h	Proposed Opening Date	<p>The date the site is scheduled to be open for business.</p> <p>Must be within 3 months of the date you submit the form.</p>

2. PROVIDER TYPE

Please note that a provider can be in more than one class and/or sub-class as long as they meet the requirements for each of those classes or sub-classes.

For example:

- A community pharmacy that serves Plan B facilities and has a trained breast prosthesis fitter onsite should select the **Community Pharmacy** and **Device** classes as well as the **Plan B Pharmacy** and **Breast Prosthesis Provider** sub-classes.
- A community pharmacy that dispenses ostomy supplies needs to select **only** the **Community Pharmacy** class.
- A site that provides ostomy and/or diabetes supplies but is **not** a pharmacy should select the **Device** class and **Other** in the Device Sub-class section.
- A recognized limb prosthetist would select the **Device** class and **Limb Prosthesis Provider** sub-class.

FIELD ID	FIELD NAME	INSTRUCTIONS
a	Pharmacy Class:	<ul style="list-style-type: none"> • Pharmacies may enroll as a Community Pharmacy or an Out-Patient Hospital Pharmacy based on the pharmacy’s licence. • In-patient–only pharmacies are ineligible for enrollment. • If enrolling in the community pharmacy or out-patient hospital pharmacy class, include a copy of your pharmacy licence.
b	Pharmacy Sub-classes:	<ul style="list-style-type: none"> • Pharmacies may also enroll in the Opioid Agonist Treatment Provider and Plan B Pharmacy sub-classes. • Pharmacies that also provide general medical supplies (such as diabetes supplies, insulin pumps and supplies, blood glucose test strips and ostomy supplies) do not need to apply for enrollment in the Device class unless they wish to provide one or more of the following: <ul style="list-style-type: none"> ▪ Compression garments ▪ Limb prostheses ▪ Breast prostheses ▪ Ocular prostheses ▪ Orthoses ▪ A pharmacy wishing to enroll in the Opioid Agonist Treatment Provider sub-class must confirm that all pharmacists providing any OAT services have successfully completed the required training for the provision of OAT drugs and services: <i>Effective January 1, 2019:</i> <ul style="list-style-type: none"> ▪ All pharmacy managers, staff pharmacists, and relief pharmacists employed in a community pharmacy that provides pharmacy services related to buprenorphine/naloxone maintenance treatment, methadone maintenance treatment or slow release oral morphine maintenance treatment must:

FIELD ID	FIELD NAME	INSTRUCTIONS
		<ul style="list-style-type: none"> ▪ successfully complete the College of Pharmacists of BC (CPBC) Methadone Maintenance Treatment (MMT) training program (2013), or ▪ successfully complete the British Columbia Pharmacy Association (BCPhA) Opioid Agonist Treatment Compliance and Management Program for Pharmacy (OAT-CAMPP) training program <p><i>Effective September 30, 2021:</i></p> <ul style="list-style-type: none"> ▪ The CPBC MMT training program (2013) will not be available beyond September 30, 2021. Registrants will no longer be able to fulfill the College’s training requirements by completing that program, and must complete any applicable component(s) of the BCPhA OAT-CAMPP by September 30, 2021. ▪ A pharmacy can enroll in the Plan B Pharmacy sub-class if the pharmacy or the facility being serviced provides a copy of the facility licence to Health Insurance BC once it is available.
c	Device class:	<ul style="list-style-type: none"> • Sites that provide medical supplies and devices may enroll in the Device class. • If you are enrolling in the device class, please include a copy of your business licence (unless you are a pharmacy).
d	Device Sub-classes:	<ul style="list-style-type: none"> • Device providers may enroll in the following sub-classes: Compression Garment Provider, Limb Prosthesis Provider, Breast Prosthesis Provider, Ocular Prosthesis Provider, and Orthosis Provider. • Device providers that are not applying for any sub-classes listed above should indicate the type of claims they will be submitting to PharmaCare by checking either Insulin Pump Manufacturer/ Distributor or Other (ostomy supplies, diabetes supplies). • Device providers wishing to enroll in the Limb Prosthesis Provider, Orthosis Provider, Ocular Prosthesis Provider, Breast Prosthesis Provider, or Compression Garment Provider sub-classes must confirm that each person providing benefits is recognized by the appropriate Board/manufacture (see 3. Sub-Class Eligibility).

3. SUB-CLASS ELIGIBILITY

Answer only the questions that apply to your site as indicated in section 2 of the **Enrollment Form**.

If you answered **No** to any of the questions, **attach a written explanation** as to why PharmaCare should consider enrolling you in this sub-class. Please note that you cannot be enrolled unless you meet the requirements or the Ministry of Health determines that enrolling your site:

- would not present a risk to the integrity of PharmaCare, or
- would be in the public interest.

4. SOFTWARE VENDOR

If you use PharmaNet to submit claims, indicate your **software vendor** and **software version**. Contact your software vendor for more information, if necessary.

5. OWNER INFORMATION

Different information will need to be provided depending on the type of ownership structure of the site.

FIELD ID	FIELD	INSTRUCTIONS
a	Type of ownership	<ul style="list-style-type: none"> • Please indicate if the site is owned by a sole proprietorship, partnership, corporation, health authority or other. <ul style="list-style-type: none"> ▪ Sole proprietorship means the site is owned by a single individual. (If you are an incorporated sole proprietorship, check “Corporation” only.) ▪ Partnership means the site is owned by two or more individuals. ▪ Corporation means the site is owned by a corporation. ▪ Health authority means the out-patient hospital pharmacy is owned or operated by a health authority ▪ If your Ownership type does not match any of the types above, select Other and specify the ownership type.
b	Registered or legal name of sole proprietor, partnership, corporation or name of health authority	<ul style="list-style-type: none"> • For a sole proprietorship, the name of the person who owns the site • For a partnership, the name of the partnership • For a corporation, the registered name of the corporation (e.g. 1234567 BC Ltd.) • For an out-patient hospital pharmacy, the name of the health authority
c	Mailing Address/ Contact Information	<ul style="list-style-type: none"> • The address where the sole proprietor/partnership/corporation/health authority can be contacted, including the phone number, fax number and email address
d	Owner Documentation Requirements	<ul style="list-style-type: none"> • Please ensure the Site ID is indicated on all documents submitted. • Provide all the following, as applicable. If you are unsure of the documentation to include, please consult your legal counsel. <ul style="list-style-type: none"> ▪ For a partnership: the list of partners and contact information on Schedule A: Owner Details ▪ For B.C. incorporated corporations that are not publicly traded (including subsidiary corporations*): a copy of the BC Company Summary, the securities register and any relevant provisions of any shareholder agreements with respect to the operation of the site ▪ For B.C. incorporated publicly traded corporations (including subsidiary corporations): a copy of the BC Company Summary. In the case of a subsidiary corporation, the requirement to provide information respecting the directors, officers and shareholders of the parent corporation is waived.

FIELD ID	FIELD	INSTRUCTIONS
D, <i>continued</i>		<ul style="list-style-type: none"> ▪ For federally incorporated corporations that are not publicly traded (including subsidiary corporations*): provide the names and contact information of all officers and directors on Schedule A: Owner Details and a copy of the shareholder’s register and any relevant provisions of any shareholder agreements with respect to the operation of the site ▪ For federally incorporated publicly traded corporations (including subsidiary corporations): provide the names and contact information of all officers and directors on Schedule A: Owner Details. In the case of a subsidiary corporation, the requirement to provide information respecting the directors, officers and shareholders of the parent corporation is waived. ▪ For 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) <p>* Note: For subsidiary corporations that are not publicly traded and which have a parent corporation that is not publicly traded, you must also include—for the parent corporation—the names and contact information of all officers and directors on Schedule A: Owner Details and a copy of the shareholder’s register and any relevant provisions of any shareholder agreements with respect to the operation of the site.</p>

6. ADDITIONAL SITES

Additional information is required if any **owner** or **manager** of the site being enrolled also owns or manages:

- other sites in B.C. (regardless of whether they are enrolled in PharmaCare), and/or
- sites outside B.C. that are enrolled in PharmaCare.

IMPORTANT:

- 1) If your site is a subsidiary corporation, you must provide information respecting the directors, officers and shareholders of the parent corporation if both the subsidiary corporation and the parent corporation **are not** publicly traded. If either the subsidiary corporation or the parent corporation **is** publicly traded, the requirement to provide information respecting directors, officers and shareholders of the parent corporation is waived.
- 2) If an owner of your site owns or manages any site located outside of B.C. and no application for enrollment for that site is being made, the requirement to provide the operating name of that site is waived.

Please specify the owner’s name, the **operating name**, position held and **Site ID** of these other sites on [Schedule B: Additional Sites](#).

If you are an owner who is enrolling multiple sites at the same time, please attach a list that includes all sites with each application (i.e., complete **Schedule B** once and attach a copy to each application).

7. ADDITIONAL INFORMATION

All applicants must answer questions 1-8. To enroll as both a device provider and a pharmacy, answer all questions in this section. To enroll as a pharmacy only, answer questions 9-11. If you are asking to enroll as a device provider only, skip questions 9-11 but answer question 12.

If you answer **Yes** to any of the questions in section 7 of the Enrollment Form, please provide the additional information requested below (as applicable) on [Schedule C: Additional Information](#).

If you answer **Yes** to any of the questions, **attach a written explanation** as to why PharmaCare should consider enrolling you. Please note that if you answer **Yes** to any of the questions other than Questions 8, 11 or 12, you cannot be enrolled unless the Ministry of Health determines that enrolling your site:

- would not present a risk to the integrity of PharmaCare, or
- would be in the public interest.

QUESTION	INFORMATION TO INCLUDE IF YOU ANSWERED “YES”
1a	<ul style="list-style-type: none"> • Name(s) of the owner/manager who is currently required to pay the monies • To whom the amount must be paid • Amount owing • Payment due date • Audit period (e.g., January 1, 2013, to December 31, 2013) • Name and, if applicable, the Site ID of site audited
1b	<ul style="list-style-type: none"> • Name of the entity (corporation or person) that is currently required to pay the monies • Name of the owner/manager who owned/managed the site during the audit period • To whom the amount must be paid • Amount owing • Payment due date • Audit period (e.g., January 1, 2013, to December 31, 2013) • Name and, if applicable, the Site ID of site audited
2a	<ul style="list-style-type: none"> • Name(s) of the owner/manager of this site who was the subject of the order or conviction • Description of the events that resulted in the order or conviction, including when the events occurred • Name of the entity that issued the order or conviction • Date of the order or conviction • The name and, if applicable, the Site ID of the site where the events that resulted in the order or conviction took place, if applicable • Penalty imposed as a result of the order or conviction (e.g., fine, imprisonment)

QUESTION	INFORMATION TO INCLUDE IF YOU ANSWERED “YES”
2b	<ul style="list-style-type: none"> Name(s) of the owner/manager of this site who owned/managed the other site when the information or billing contravention occurred Description of the events that resulted in the order or conviction, including when the events occurred Name of the entity that issued the order or conviction Date of the order or conviction The name and, if applicable, the Site ID of the site in relation to which the order or conviction was issued Penalty imposed as a result of the order or conviction (e.g., fine, imprisonment)
3a	<ul style="list-style-type: none"> Name(s) of the owner/manager whose billing privileges are suspended Description of the events that resulted in the suspension of billing privileges, including when the events occurred Name of the entity that suspended the billing privileges Period for which billing privileges are suspended The name and, if applicable, the Site ID of the site in relation to which billing privileges are suspended
3b	<ul style="list-style-type: none"> Name(s) of the owner/manager of this site who owns/manages the other site for which billing privileges are suspended Description of the events that resulted in the suspension of billing privileges, including when the events occurred Name of the entity that suspended the billing privileges Period for which billing privileges are suspended The name and, if applicable, the Site ID of the site in relation to which the billing privileges are suspended
4a	<ul style="list-style-type: none"> Name(s) of the owner/manager of this site whose billing privileges were cancelled Description of the events that resulted in the cancellation of billing privileges, including when the events occurred Name of the entity that cancelled the billing privileges Date of the cancellation The name and, if applicable, the Site ID of the site in relation to which billing privileges were cancelled
4b	<ul style="list-style-type: none"> Name(s) of the owner/manager of this site who owned/managed the other site when the incident giving rise to the cancellation of billing privileges occurred Description of the events that resulted in the cancellation of billing privileges, including when the events occurred Name of the entity that cancelled the billing privileges Date of the cancellation The name and, if applicable, the Site ID of the site in relation to which the billing privileges were cancelled

QUESTION	INFORMATION TO INCLUDE IF YOU ANSWERED “YES”
5	<ul style="list-style-type: none"> • Name(s) of the owner/manager of this site against whom the judgment was issued • Description of the events in relation to which the judgment was issued, including when the events occurred • The name and, if applicable, the Site ID of the site in relation to which the events occurred
6	<ul style="list-style-type: none"> • Name(s) of the owner/manager of this site who was convicted of any offence prescribed in section 22 (1) of the Provider Regulation • Specify for which of the following offence(s) the owner/manager was convicted: <ul style="list-style-type: none"> ▪ Sections 362, 366, 380, 388, 389, 392, 397, 402, 402.2, 403 and 408 of the <i>Criminal Code</i>. ▪ Section 5 of the <i>Controlled Drugs and Substances Act</i> ▪ Section 46 of the <i>Controlled Drugs and Substances Act</i> related to: <ul style="list-style-type: none"> ▪ Part 2 of the Benzodiazepines and Other Targeted Substances Regulations ▪ Sections 30-45 of the Narcotic Control Regulations • Description of the events that resulted in conviction, including when the events occurred • Name of the court that issued the conviction • Date of the conviction • The name and, if applicable, the Site ID of the site where the events that resulted in the conviction took place, if applicable • Penalty imposed as a result of the conviction (e.g., fine, imprisonment)
7	<ul style="list-style-type: none"> • Name(s) of the owner/manager of this site whose PharmaCare enrollment was cancelled • Description of the events that resulted in the cancellation of PharmaCare enrollment, including when the events occurred • Date of the cancellation • The name and Site ID of the site in relation to which PharmaCare enrollment was cancelled • Which class/sub-class was cancelled (e.g., Opioid Agonist Treatment Provider, Plan B)
8	<ul style="list-style-type: none"> • Name of the owner of this site who was a director of a corporation that declared or was petitioned into bankruptcy • When bankruptcy was declared/petitioned
9	<ul style="list-style-type: none"> • Name(s) of the owner/manager of this site whose pharmacy licence has been suspended or cancelled • Description of the events that resulted in the suspension or cancellation, including when the events occurred • Name of the entity that suspended or cancelled the licence • Period of suspension or date of cancellation • The name and, if applicable, the Site ID of the site in relation to which the licence was suspended or cancelled

QUESTION	INFORMATION TO INCLUDE IF YOU ANSWERED “YES”
10	<ul style="list-style-type: none"> Name(s) of the owner/manager of this site whose registration as a pharmacist was suspended or cancelled Description of the events that resulted in the suspension or cancellation of the registration, including when the events occurred Name of the governing body of pharmacists that suspended or cancelled the registration Period of suspension or date of cancellation
11	<ul style="list-style-type: none"> Name(s) of the owner/manager of this site upon whom limits or conditions were imposed as a result of disciplinary actions taken by a governing body of pharmacists (e.g., College of Pharmacists of BC, Alberta College of Pharmacists) Description of the events that resulted in the limits or conditions being imposed, including when the events occurred Description of limits or conditions imposed Name of the governing body that imposed the limits or conditions Date that the limits or conditions were imposed and, if applicable, removed The name and, if applicable, the <i>Site ID</i> of the site in relation to which the limits or conditions were imposed
12	<ul style="list-style-type: none"> Name(s) of the owner/manager of this site upon whom limits, conditions or prohibitions were imposed as a result of disciplinary actions taken by the Canadian Board for Certification of Prosthetists and Orthotists Description of the events that resulted in limits, conditions or prohibitions being imposed, including when the events occurred Description of limits, conditions or prohibitions imposed Date that the limits, conditions or prohibitions were imposed and, if applicable, removed The name and, if applicable, the <i>Site ID</i> of the site in relation to which the limits, conditions or prohibitions were imposed

8. SIGNATURE OF AUTHORIZED REPRESENTATIVE OF THE APPLICANT

The applicant is the legal owner. For example, in the case of a site owned by a corporation, the “applicant” is the corporation.

FIELD NAME	INSTRUCTIONS
Signature	Signature of the authorized representative of the applicant
Name	Name of the authorized representative of the applicant
Title	Title of the authorized representative of the applicant
Date signed	Date the form was signed
Phone number	Phone number where the applicant’s authorized representative may be contacted

SUBMITTING YOUR APPLICATION

Submit your application and related documents by mail or fax:

PharmaCare Information Support

Health Insurance BC

P.O. Box 9684 Stn Prov Govt

Victoria BC V8W 9P7

Fax: (250) 405-3599

NOTIFICATION REQUIREMENTS

As the owner of a site, you must notify PharmaCare, in advance, of changes to your business (such as changes of ownership, management etc.) and, if applicable, your PharmaNet connection.

Failure to abide by your duties and obligations may result in delay or suspension of payments. Please read the materials included in your Welcome Package thoroughly, to ensure you understand your duties and obligations as a PharmaCare provider.

Once you have submitted your application, notify the Ministry of Health (via form submitted to Health Insurance BC) of any of the following in accordance with the notification requirement specified below:

CHANGE	NOTIFICATION REQUIREMENT
Change in provider contact information	Minimum 7 days before change
Change of operating/business or corporate name	Minimum 7 days before change
Change in owner information	Minimum 7 days before change
Change of manager	Minimum 7 days before change
Change of location	Minimum 7 days before change
Changes to a Power of Attorney	Minimum 7 days before change
Cancellation of sub-class	Opioid Agonist Treatment Provider —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
Request to add a sub-class	Recommended notification period: Submit the request at least 21 days in advance of requested effective date to allow for processing.
Notice of certain action or event(s)*	Immediately
Notice of disposition (sale) or closure	Minimum 30 days before change.

*Actions or events include: 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; and, a requirement to pay an amount to a public insurer, other than BC PharmaCare.

Notify PharmaCare Information Support of any of these changes using the [PharmaCare Provider Change Form \(HLTH 5433\)](#).

Please retain a copy of your Enrollment Form and all Change Forms. If you are required to notify the Ministry of Health of a change using the [PharmaCare Provider Change Form \(HLTH 5433\)](#), you must ensure that information on HLTH 5433 matches the corresponding information on your Enrollment Form, or the last Change Form you submitted.

QUESTIONS?

If you have read the instructions and still have questions, contact PharmaCare Information Support via the PharmaNet Help Desk:

- Vancouver: (604) 682-7120
- Elsewhere in BC: 1-800-554-0225