BRITISH COLUMBIA
The Best Place on Earth

Health InsuranceBC

MEDICAL SERVICES PLAN (MSP)
PAY RECIPROCAL PRACTITIONER CLAIM

CLAIMS MUST BE SUBMITTED WITHIN 90 DAYS

A B C D PLEASE USE CAPITAL LETTERS ONLY

PATIENT INFORMATION

PROVINCE/ TERRITORY

REGISTRATION NUMBER

PATIENT LEGAL FIRST NAME

SECOND NAME INITIAL

PATIENT LEGAL LAST NAME

GENDER

M F

PATIENT BIRTHDATE (MM / DD / YYYY)

MVA RELATED? YES

IF YES, MVA CLAIM NUMBER

CORRESPONDENCE ATTACHED

SUBMISSION CODE

APT / UNIT

STREET NUMBER

STREET NAME

CITY

PROVINCE

POSTAL CODE

SERVICE(S)

DATE OF SERVICE MONTH	DAY	YEAR	NO. OF SERVICES	S.C.C.	FEE ITEM	AMOUNT BILLED	TIME CALLED START	TIME RENDERED FINISH	DIAGNOSTIC CODE	LOC. OF SERV.

HOSPITAL VISITS

DATE OF SERVICE MONTH	DAY FROM - TO	YEAR	NO. OF SERVICES	S.C.C.	FEE ITEM	AMOUNT BILLED	DIAGNOSTIC CODE	LOC. OF SERV.

DIAGNOSIS OR AREA OF TREATMENT

PRACTITIONER INFORMATION

PRACTITIONER LAST NAME OR CLINIC NAME

FIRST NAME INITIAL

PRACTITIONER SIGNATURE

PAYMENT NUMBER

PRACTITIONER NUMBER

REFERRED BY

PRACTITIONER NUMBER

REFERRED BY (PRACTITIONER LAST NAME)

FIRST NAME INITIAL

REFERRED TO

PRACTITIONER NUMBER

REFERRED TO (PRACTITIONER LAST NAME)

FIRST NAME INITIAL

Mailing Address: Health Insurance BC, Medical Services Plan, PO Box 9689 Stn Prov Govt, Victoria BC V8W 9P8
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