BRITISH COLUMBIA | Health InsuranceBC

# REIMBURSEMENT REQUEST

MC

A B C D PLEASE USE CAPITAL LETTERS ONLY

This form is to be used only for specific circumstances. You must select one of the following boxes below to be able to use this form:

- ☐ You are an eligible beneficiary requesting reimbursement for payment when MSP coverage has been backdated prior to the service date.
- ☐ You are a beneficiary who is eligible for supplementary benefits claiming the MSP paid portion of a supplementary benefit service.
- ☐ You did not present a valid BC Services Card at the time of service.

MSP pays for medically required services according to the Medical Services Commission Payment Schedule. All claims are subject to the MSP rules and regulations. For more information visit:
www.gov.bc.ca/gov/content/health/practitioner-professional-resources/msp/physicians/payment-schedules/msc-payment-schedule.

**Please include an itemized statement and proof of payment.** Claims must be submitted within 90 days of the date of service. In exceptional cases there will be consideration of claims over 90 days old.

**Note: In certain circumstances practitioners are permitted to charge their patients directly. (For example: the patient does not present their BC Services Card when service is provided). The practitioner may charge more for the service than MSP will reimburse. The patient can use this form to be reimbursed for their MSP portion. It is the patient's responsibility to pay the difference.**

## 1 PATIENT INFORMATION

PATIENT LEGAL LAST NAME | PATIENT LEGAL FIRST NAME | PATIENT LEGAL SECOND NAME

PERSONAL HEALTH NUMBER (PHN) | BIRTHDATE (MM / DD / YYYY) | DAYTIME PHONE NUMBER

APT / UNIT | STREET NUMBER | STREET NAME

CITY | PROV | POSTAL CODE

## 2 CLAIMS INFORMATION

**If you have receipts from more than one practitioner or facility submit separate forms for each.**

NAME OF MEDICAL PRACTITIONER OR FACILITY PROVIDING SERVICE | PHONE NUMBER

NAME OF REFERRING PHYSICAN (IF APPLICABLE) | PHONE NUMBER

| CLAIM ITEM | DATE(S) OF SERVICE MM / DD / YYYY | FEE ITEM / TYPE OF SERVICE PROVIDED | AMOUNT |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |
| 4 | | | |
| 5 | | | |

For more than 5 claims items for one practitioner or facility, please submit another sheet.

## 3 PATIENT SIGNATURE

SIGNATURE OF PATIENT | DATE SIGNED (MM / DD / YYYY)

Personal information is collected under the authority of the *Medicare Protection Act* and section 26 (a), (c) and (e) of the *Freedom of Information and Protection of Privacy Act* for the purposes of administration of the Medical Services Plan. If you have any questions about the collection and use of your personal information, please contact the Health Insurance BC Chief Privacy Office at Health Insurance BC, Chief Privacy Office, PO Box 9035 STN PROV GOVT, Victoria, BC V8W 9E3 or call 604 683-7151 (Vancouver) or 1 800 663-7100 (toll-free).

Mailing Address: Patient Benefits, PO Box 9480 Stn Prov Govt, Victoria BC V8W 9E7
Tel: (Lower Mainland) 604 456-6950, (Rest of BC) 1 866 456-6950 Web: **www.hibc.gov.bc.ca**

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