

## **APPLICATION FOR MSP BILLING NUMBER (DENTAL)**

To be completed by **new applicants** who do not have a valid MSP billing number; are registered with the College of Dental Surgeons of British Columbia and wish to obtain a Medical Services Plan billing number.

1. PERSONAL INFORMATION						
SURNAME	GIVEN NAME (FIRST)	GIVEN NAME (SECOND)				
LEGAL NAME		ı				
DATE MM DD YYYY OF BIRTH	☐ M ☐ F CITIZENSHIP ☐ OTHER		If non-Canadian, indicate your status in Canada and enclose a copy of your Work Permit and/or Landed Immigrant status papers.			
BUSINESS MAILING ADDRESS			CITY		POSTAL CODE	
PHONE NUMBER	FAX NUMBER	EMAIL ADDRES	EMAIL ADDRESS			
HOME ADDRESS (NUMBER AND STREET)			CITY		POSTAL CODE	
PHONE NUMBER	MBER FAX NUMBER		EMAIL ADDRESS			
2. EDUCATION AND CERTIFICATION						
GRADUATED FROM:				DATE OF E	ENTRY (MM / DD / YYYY)	
CHECK APPLICABLE SPECIALTY(S):				DATE OF C	GRADUATION (MM / DD / YYYY)	
☐ ENDODONTIST	EFFECTIVE DATE (MM / DD / YYYY)	ORTHOD	OONTIST	EFFECTIVE	E DATE (MM / DD / YYYY)	
GENERAL PRACTITIONER DENTIST	EFFECTIVE DATE (MM / DD / YYYY)	l —	IC DENTIST	EFFECTIVE	E DATE (MM / DD / YYYY)	
ORAL & MAXILLOFACIAL SURGEON	EFFECTIVE DATE (MM / DD / YYYY)	PERIODO	ONTIST	EFFECTIVE	E DATE (MM / DD / YYYY)	
ORAL MEDICINE  EFFECTIVE DATE (MM / DD / YYYY)		l —	PROSTHODONTIST		E DATE (MM / DD / YYYY)	
3. REGISTRATION: COLLEGE OF DENTAL SURGEONS OF BRITISH COLUMBIA						
DATE OF REGISTRATION (MM / DD / YYYY) COLLECT	GE REGISTRATION #					
EFFECTIVE DATE (MM / D	EFFECTIVE DATE (MM / DD / YYYY) OR		EFFECTIVE DATE (MM / DD / YYYY)		CANCELLATION DATE (MM / DD / YYYY)	
FULL LICENSE	TEI	MPORARY LICENSE				
4. PAYMENT						
IMPORTANT: DO YOU WISH TO BE OPTED IN OR OPTED OUT OF THE MEDICAL SERVICES PLAN?  OPT IN (BILL THE MEDICAL SERVICES PLAN)  OPT OUT (BILL THE PATIENT)						
To apply for Direct Bank Payment from MSP BC, please complete the Application for Direct Bank Payment (HLTH 2832), https://www2.gov.bc.ca/assets/gov/health/forms/2832fil.pdf						
5. DECLARATION AND SIGNATURE						
I understand that MSP is a public system based on trust, but also that my claims are subject to audit and financial recovery for claims contrary to the <i>Medicare Protection Act</i> (the "Act"). I undertake to not						
submit false or misleading claims information, and acknowledge that doing so is an offence under the Act and may be an offence under the Criminal Code of Canada. Further, I agree that I will meet						
the requirements of the Act and related Payment Schedule regarding claims for payment, including that <b>prior to submitting a claim</b> I must create: (a) an adequate medical record, if I am a medical practitioner; or (b) an adequate clinical record, if I am a health care practitioner.						

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: Provider Programs, PO Box 9480 Stn Prov Govt, Victoria BC V8W 9E7
Tel: (Lower Mainland) 604 456-6950, (Rest of BC) 1 866 456-6950 FAX: 250 405-3592 Web: www.hibc.gov.bc.ca