

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

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

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. PERSONAL INFORMATION  SURNAME GIVEN NAME (		GIVEN NAME (FIRST)	T) GIVEN NAME (SECOND)	
LEGAL		GIVER TO WIE (THIST)		TVENTONIE (SECONO)
NAME				
DATE MM DD YYYY	☐ M ☐ F CITIZENSHIP			n-Canadian, indicate your status in Canada and ose a copy of your Work Permit and/or Landed
OF BIRTH	OTHER			grant status papers.
BUSINESS MAILING ADDRESS			CITY	POSTAL CODE
PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS		
	TO THE STATE OF TH			
			T	
ADDRESS (NUMBER AND STREET)			CITY	POSTAL CODE
PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS		
2. EDUCATION AND CERTIFICA	ATION			
MEDICAL SCHOOL				DATE OF GRADUATION (MM / DD / YYYY)
ROYAL COLLEGE SPECIALTY				DATE OF CERTIFICATION (MM / DD / YYYY)
ROYAL COLLEGE SUB-SPECIALTY				DATE OF CERTIFICATION (MM / DD / YYYY)
NON ROYAL COLLEGE SPECIALTY			DATE OF CERTIFICATION (MM / DD / YYYY)	
NON ROYAL COLLEGE SUB-SPECIALTY			DATE OF CERTIFICATION (MM / DD / YYYY)	
3. REGISTRATION: COLLEGE O	F PHYSICIANS AND SUF	RGEONS OF BRITISH C	OLUMBIA	
DATE OF REGISTRATION (MM / DD / YYYY) COLL	EGE ID # (CPSID)	RESTRICTIONS (IF ANY)		
EFFECTIVE DATE (MM.	/ DD / YYYY)		CTIVE DATE (MM / DD / YYYY)	CANCELLATION DATE (MM / DD / YYYY)
FULL LICENSE		TEMPORARY LICENSE EDUCATION	1 1	
4 DAYMENT		EDUCATION		
4. PAYMENT INDICATE TYPE OF PAYMENT YOU WILL BE SEEKING (	( annronriate hoves)			
HOSPITAL OR AGENCY FUNDED	APB SALARIED OR SESSIONAL	FEE FOR SERVICE	OTHER (specify):	
_				gov.bc.ca/assets/gov/health/forms/2832fil.pdf
****		ion for Direct Bank Payment (TE	111 2032), <u>Ittps://www2.</u>	gov.bc.ca/assets/gov/neartii/10/ms/2052m.pui
5. DECLARATION AND SIGNATURE  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 prior to submitting a slaim I must create (a) an adequate medical record if I am a medical				
that <b>prior to submitting a claim</b> rimust create. (a) an adequate medical record, if rain 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