



CLAIMS MUST BE SUBMITTED WITHIN 90 DAYS. PLEASE DO NOT FAX THIS FORM.

To ensure this claim is processed, please follow instructions on page 2.

A B C D USE CAPITAL LETTERS ONLY

PATIENT INFORMATION

PERSONAL HEALTH NUMBER (PHN), DEPENDANT, PATIENT BIRTHDATE (MM / DD / YYYY), PATIENT LEGAL FIRST NAME, SECOND NAME INITIAL, PATIENT LEGAL LAST NAME, MVA RELATED? IF YES, MVA CLAIM NUMBER, CORRESPONDENCE ATTACHED, SUBMISSION CODE, PLAN REFERENCE NUMBER OF ORIGINAL CLAIM

SERVICE(S)

Table with columns: MONTH, DATE OF SERVICE (DAY, YEAR), NO. OF SERVICES, S.C.C., FEE ITEM, AMOUNT BILLED, CALLED START, TIME RENDERED FINISH, DIAGNOSTIC CODE, SERV. LOC. CODE

HOSPITAL VISITS

Table with columns: MONTH, DATE OF SERVICE (DAY FROM - TO, YEAR), NO. OF SERVICES, S.C.C., FEE ITEM, AMOUNT BILLED, DIAGNOSTIC CODE, SERV. LOC. CODE

NOTES/ADDITIONAL INFORMATION

PRACTITIONER INFORMATION

PRACTITIONER LAST NAME, PRACTITIONER FIRST NAME, PAYMENT NUMBER, PRACTITIONER NUMBER, SPEC. CODE, FACILITY NUMBER, PRACTITIONER SIGNATURE, REFERRED BY, PRACTITIONER NUMBER, REFERRED BY (PRACTITIONER LAST NAME), FIRST NAME INITIAL, COVERED PRE-AUTHORIZATION NUMBER, REFERRED TO, PRACTITIONER NUMBER, REFERRED TO (PRACTITIONER LAST NAME), FIRST NAME INITIAL

INSTRUCTIONS FOR COMPLETING AND SUBMITTING THIS CLAIM

Only the following claim types can be submitted by mail using this downloadable “fill, print and mail” Claim Form:

- Correctional facilities claims
- Claims for patients covered under the Critical Care Coverage Program

If a practitioner can demonstrate that they reside in a community without internet access or that obtaining internet access will cause significant financial hardship, they can submit their claims via mail using a Claim Form. To receive paper copies of the Claims Form, practitioners must request an exemption in writing demonstrating that obtaining internet access will cause significant hardship. Requests for an exemption should be sent to Health Insurance BC at the address listed at the bottom of page 1. All other forms must be submitted electronically

Mail the completed form to the address that appears at the bottom of page 1 of this form.

Claims must be submitted to the Medical Services Plan (MSP) within 90 days of the date of service.

PATIENT INFORMATION

In order for MSP to process this claim, the following areas must be completed:

- patient’s PERSONAL HEALTH NUMBER
- PATIENT’S LEGAL FIRST NAME, first initial of SECOND NAME (if you legally have a second name), and LAST NAME
- PATIENT BIRTHDATE (day, month and year)

PRACTITIONER AND SERVICES INFORMATION

Please ensure that all the areas listed below are completed. Otherwise, we will be unable to process your claim.

- DATE OF SERVICE
- NO. (number) OF SERVICES
- S.C.C. (service clarification code)—if applicable
- FEE ITEM
- AMOUNT BILLED
- DIAGNOSTIC CODE
- SERVICE LOCATION CODE
- PRACTITIONER LAST NAME
- PRACTITIONER FIRST NAME
- PRACTITIONER SIGNATURE
- PAYMENT NUMBER
- PRACTITIONER NUMBER

Please allow 4 to 6 weeks for processing claims for routine medical services. Specialist services may require additional processing time.