BRITISH COLUMBIA | Health InsuranceBC

MEDICAL SERVICES PLAN (MSP)
PAY RECIPROCAL PRACTITIONER CLAIM

PR

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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