



INSTRUCTIONS

- 1** If this is an initial claim, fill out the Enhanced Urgent Care Coverage Program form (HLTH 1980, page 2 of this PDF).
If you are submitting a subsequent claim, attach a copy of original HLTH 1980 to the HLTH 1915 below.
- 2** Fill out the MSP Pay Practitioner Claim form (HLTH 1915, attached at the end of this PDF).
- 3** Mail both forms, along with accompanying documents to the address listed at the bottom of HLTH 1915.

Please see detailed instructions on page 3-5 of this PDF



ENHANCED URGENT CARE COVERAGE PROGRAM

Patient Label

Facility ID Number (location where the initial service took place)	Date (YYYY / MM / DD)
Hospital Name	Department / Facility Name

PATIENT INFORMATION

<input type="checkbox"/> Check if Applicable <input type="checkbox"/> Patient has been a resident of BC for at least 3 months, is not enrolled in MSP, and has not opted out of coverage		Personal Health Number (PHN)
Legal Last Name	Legal First Name	Legal Second Name(s) or Initial
Birthdate (YYYY / MM / DD)	Address	

RESIDENCY (One of the following options for confirming Patient Residency must be selected)

Option 1: Primary Identification (ID) & Proof of Residency Document

1 *Note: Refer to the PATIENT INFORMATION and RESIDENCY sections on pages 3-4 for a list of valid Primary ID types and acceptable Proof of Residency documents.*

<input type="checkbox"/> Primary ID Provided	Type of ID Provided	ID Number	<input type="checkbox"/> Proof of Residency Document attached
--	---------------------	-----------	---

Option 2: Attestation Method

2 *Note: If no Proof of Residency Documentation is available, residency requirements may be established via questionnaire. If no Primary ID is available, Attestation Method is required. Please refer to pages 4-5 for more information. The information provided may be subject to an audit.*

<input type="radio"/> Primary ID Provided	<input type="radio"/> ID Provided, but not Primary*	Type of ID Provided	ID Number
<input type="radio"/> No ID Provided* <i>*Attestation Method Required</i>			
If Proof of Residency document available: <input type="checkbox"/> Proof of Residency attached	If NO Proof of Residency available: <input type="checkbox"/> Attestation of Residency obtained	Date of Arrival in BC (YYYY / MM / DD)	Citizenship / Residence Status in Canada

Physician and Witness signatures are NOT required if Advocate signature is provided.

Advocate Name	OR	Physician Name	Witness Name
Advocate Signature		Physician Signature	Witness Signature

MEDICAL SERVICES

Note: Describe criteria met for urgent care (e.g., assessment required for abdominal pain to rule out sinister causes). Include diagnostics, diagnosis details, any other relevant information. Refer to the EUCCP criteria on page 3. **Please use Form 1915 for listing specific services provided for billing purposes.**

Please indicate if you foresee additional services or other physician involvement during patient stay.
 Yes No If Yes, specify additional services:

URGENT CARE DECLARATION AND SIGNATURE (required)

I declare that the patient meets the residency and Enhanced Urgent Care Coverage Program (EUCCP) criteria.

Physician Name	MSP Practitioner Number	Physician Signature	Date Signed (YYYY / MM / DD)
----------------	-------------------------	---------------------	------------------------------

Enhanced Urgent Care Coverage Program (EUCCP) Claims Coverage Criteria:

Physicians may only claim EUCCP if they have not received payment for service through other means. Compensation for services within the Enhanced Urgent Care Coverage Program will exclusively be reviewed for:

- physicians whose expertise is necessary to attend to the immediate needs of a patient arriving at the emergency department, encompassing surgical services; and
- physicians providing subsequent healthcare services to a previously admitted EUCCP patient while the patient remains in hospital.

Ensure patient meets residency and urgent care criteria as outlined in the EUCCP guidelines below.

The patient must present in a BC emergency department with at least one of the following medical conditions for which documentation is provided to MSP:

- i. Medical assessment of individual presenting at the emergency department, such as to assure the attending physician that there is not otherwise a risk to the patient's long term health,
- ii. Urgent medical need ranging in seriousness, requiring professional attention that could threaten an individual's life or long-term health if delayed; such as (but not limited to) cancer treatment, psychiatric care, drug/alcohol rehabilitation, infection, ob/gyn care, trauma, etc.,
- iii. Unconsciousness;
- iv. An emergency condition that requires immediate admission to an intensive care unit (or equivalent, e.g., cardiac arrest, drug overdose); or
- v. A required involuntary admission under the *Mental Health Act*.

HLTH 1980 - EUCCP Claims Submission Instructions:

1. SUBMITTER INFORMATION:

To submit the HLTH 1980 form, a signature is required from the first attending provider of an EUCCP claim. If the patient identity and/or residency requirements are confirmed via Attestation Method, an Advocate may assist with the completion of the questionnaire. See the RESIDENCY section below for more information on how to provide a written attestation:

List of **accepted Advocates:**

- A medical practitioner;
- A registered social worker;
- A registered psychologist;
- A registered nurse;
- A nurse practitioner, or public health nurse;
- A health authority employee (i.e., Hospital Administrators including senior health authority staff but should not include accounting and billing staff);
- An individual acting as the guardian on behalf of the province.

The completed HLTH 1980 form must include the practitioner number of the first attending provider of an EUCCP claim. Initial EUCCP claims must include a wet signature on the original HLTH 1980 Form, reflecting details about the first EUCCP claim. See the section below for more instructions for submitting subsequent services claims.

2. SUBSEQUENT SERVICES CLAIMS:

All subsequent extended services provided to the patient while admitted to hospital, (if the patient stay is 20 days long and the HA hasn't managed to achieve enrolment during that time), can be claimed until the patient is discharged or leaves. If multiple physicians are involved in a patient's care without discharge, they can reuse the original HLTH 1980 form completed when the patient was last admitted to the hospital. Physicians will be required to submit the original HLTH 1980 form as a copy when submitting the HLTH 1915 form with subsequent services claims information. If a copy of the original HLTH 1980 form is unattainable, physicians will be required to complete and submit a new form.

3. PATIENT INFORMATION:

To receive payment for EUCCP claims, a PHN must be provided, and patient identity must be confirmed. Refer to the following list of valid primary ID's. Valid Primary ID: Canadian birth certificate, passport, citizenship card, permanent residency card, work/study permit, or a diplomat passport with entry stamps and acceptance foils.

4. RESIDENCY:

A resident of BC is defined as a person who is a Canadian citizen, Permanent Resident of Canada, or is a deemed resident under the Medical and Health Care Services Regulation. They must make their home in BC and be physically present in BC at least six months of the calendar year. The HLTH 1980 form may be completed for a patient who has been a resident of BC as defined above for at least three months.

Note: residents who have elected to opt out of MSP or who are within the eligibility waiting period cannot be covered with this program.

Residency Verification Method:

Option 1 – Primary ID & Proof of Residency

If a patient's identity is obtained via Primary ID (see above), and residency is confirmed with a Proof of Residency Document: confirm the type of ID and attach the necessary documentation to the claims submission. A Proof of Residency Document may include any one of the following:

- i. A utility bill in the patient's name from at least three months prior to the service being provided.
- ii. A letter from the patient's employer indicating residence of at least three months prior to the service being provided.
- iii. A letter from the police indicating that the patient has been known to them for at least three months prior to the service being provided.

Option 2 – Attestation Method

If obtaining acceptable documentation for Primary ID and/or Proof of Residency is not possible due to circumstances, a patient's identity and/or residency can be confirmed via questionnaire. The Attestation Method will be subject to an audit process and may be used to declare that the information provided on the HLTH 1980 form is both complete and accurate. For HLTH 1980 forms completed via selection of 'Option 2' -- a signature is required from either: a) an acceptable Advocate; or b) the attending physician with a Witness.

Questions to Ask the Patient – (Attestation Method):

- Have you been seen by the hospital/the physician in the last 12 months?
- Do you have healthcare coverage / are you enrolled in MSP?
- Are you new to BC? If yes, when did you arrive? If no, have you left the province in the last year? Have you lived in BC for at least 3 months or made BC one of your homes for at least 6 months of the year?
- What is your address?
- Are you employed? If yes, what is the name/location of your employer? If no, are you receiving assistance from the Ministry of Social Development and Poverty Reduction?
- Do you have relatives that can assist with your identification?

If the patient's identity is obtained via valid Primary ID (above), but Proof of Residency is NOT confirmed with supporting documentation, a written Attestation of Residency may be used. To be eligible for payment under EUCCP, the following information must be included on the HLTH 1980 form:

- Type of Primary ID
- ID Number
- Resident / mailing address (may be included under patient information section)
- Date of arrival in BC
- Citizenship or Residence status in Canada

If a Proof of Residency document is available, but the patient's identity CANNOT be confirmed via valid Primary ID, the Attestation Method may be used. Attach the Proof of Residency documentation to the claims form and indicate the type of ID and/or further identity details that can be obtained (if any). To be eligible for payment under EUCCP, ensure the information provided on the HLTH 1980 form is complete and accurate, and that it contains the necessary information below:

- Full legal name
- Birthdate
- Identification details, if available
- Resident / mailing address (may be included under patient information section)
- Date of arrival in BC
- Citizenship or Residence status in Canada

If the patient's identity and residency status are known, but can ONLY be confirmed via questionnaire, the Attestation Method may be used. Ensure the information provided on the HLTH 1980 form is complete and accurate, and that it contains the necessary information below.

- Full legal name
- Birthdate
- Identification details, if available
- Resident / mailing address (may be included under patient information section)
- Date of arrival in BC
- Citizenship or Residence status in Canada

5. URGENT CARE DECLARATION AND MEDICAL SERVICES:

Document the specific medical conditions necessitating urgent care and subsequent treatment on the HLTH 1980 form. Include any relevant information outlining the patient's condition and how they meet the criteria.

6. COMPLETE THE HLTH 1915 FORM:

Billings must be submitted by completing the HLTH 1915 form for physicians who have EUCCP claims. In addition to the mandatory fields, outlined on page 2 of the HLTH 1915 form, EUCCP claims must provide the facility ID number if known or under the Notes/Additional Information include the hospital name and department/facility name.

7. SUBMIT THE CLAIM:

Clearly label the envelope with "Attention: Enhanced Urgent Care"

Mail the completed HLTH 1980 and HLTH 1915 forms and supporting documents to: Health Insurance BC, Medical Services Plan, PO BOX 9689 STN PROV GOVT, Victoria, BC V8W 9P8.

Claims must be submitted to MSP within 90 days of the date of service. Please allow 4 to 6 weeks for processing claims for routine medical services. Some services may require additional processing time.



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

Form fields for 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

Form fields for 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.