BRITISH COLUMBIA | Health InsuranceBC

APPLICATION FOR TELEPLAN SERVICE

FOR MSP USE ONLY

USER ID: _____

DATA CENTRE NO.: _____

DEFAULT PASSWORD: _____

DATE PROCESSED: _____

TSO: _____

MAILING ADDRESS:

PLEASE PRINT YOUR NAME AND ADDRESS CLEARLY INCLUDING POSTAL CODE

NAME

ADDRESS

CITY | POSTAL CODE | PHONE NO.

ORGANIZATION NAME (if different from above) | CONTACT PERSON

TYPE OF FACILITY

☐ HOSPITAL ☐ PRACTITIONER ☐ SERVICE BUREAU ☐ VENDOR ☐ CLINIC

TELEPLAN CLAIM SUBMISSION INFORMATION

DATA CENTRE INFORMATION

NEW DATA CENTRE	OR	JOINING EXISTING DATA CENTRE	OR	JOINING SERVICE BUREAU
NAME: _____		NAME: _____		NAME: _____
CONTACT: _____		DATA CENTRE NO.: _____		DATA CENTRE NO.: _____

SYSTEM

HARDWARE

MAKE/MODEL OF COMPUTER: _____

MAKE/MODEL OF MODEM: _____ ☐ INT ☐ EXT SPEED: _____

BILLING/BUSINESS SOFTWARE (must be MSP tested and approved)

SOFTWARE NAME: _____

VENDOR: _____ SUPPLIER: _____

I MAKE APPLICATION TO UTILIZE THE TELEPLAN CLAIMS SUBMISSION SERVICE WITH THE FULL UNDERSTANDING OF, AND AGREEMENT WITH, THE REGULATIONS TO THE ***MEDICARE PROTECTION ACT.***

_____ *APPLICANT'S SIGNATURE*

_____ *DATE*

_____ *MSP PAYEE NUMBER*

NOTE: AN APPLICATION FORM IS REQUIRED FOR EVERY PAYEE NUMBER

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