BRITISH COLUMBIA | Health InsuranceBC

PRACTITIONER REGISTRATION

NOTE: *This form must be completed before a number can be issued.*

PERSONAL DATA

NAME (FULL NAME, NO INITIALS)			DATE OF BIRTH (MM / DD / YYYY)	GENDER
				☐ M ☐ F
REGISTRATION DATE WITH COLLEGE (MM / DD / YYYY)	REGISTRATION NO.	LICENCE ☐ TEMPORARY ☐ FULL	GRADUATED FROM	YEAR

CITIZENSHIP

☐ CANADIAN

If non-Canadian, indicate your status in Canada and enclose a copy of your Work Permit and/or Landed Immigrant status papers.

STATUS IN CANADA

TYPE OF PRACTITIONER

☐ NATUROPATH ☐ MASSAGE THERAPIST ☐ OPTOMETRIST ☐ ACUPUNCTURIST

☐ PODIATRIST ☐ CHIROPRACTOR ☐ PHYSICAL THERAPIST

BILLING OPTION: IMPORTANT

DO YOU WISH TO BE **OPTED IN** OR **OPTED OUT** OF THE MEDICAL SERVICES PLAN?

☐ OPT IN *(BILL THE MEDICAL SERVICES PLAN)* ☐ OPT OUT *(BILL THE PATIENT)*

PAYEE FILE INFORMATION

☐ **BUSINESS** ☐ **HOME**

MAILING ADDRESS			
CITY	POSTAL CODE	PHONE NUMBER	FAX NUMBER
PRACTITIONER SIGNATURE			DATE (MM / DD / YYYY)

Personal information on this form is collected under the authority of the *Medicare Protection Act* and will be used to process your application for a Medical Services Plan billing number and for record keeping. Please note that information you are providing may be disclosed to third-party agencies for administrative purposes, which may result in your contact information being disclosed to your clients. Information is protected from unauthorized use and disclosure in accordance with the *Freedom of Information and Protection of Privacy Act* and may be disclosed only as provided by that Act. If you have any questions about the collection of this information, contact Health Insurance BC at the address or telephone numbers below.

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**

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