



ALTERNATIVE PAYMENTS PROGRAM (APP)
ASSIGNMENT OF PAYMENT
DUE TO PRACTITIONER
UNDER THE MEDICAL SERVICES PLAN

APPLICATION MUST BE COMPLETED IN FULL

I, _____,
Physician Name

hereby assign to _____,
Service Contract Name

any and all sums of money that shall on and after the date of the signing of this Assignment that is owing to me by the Medical Services Commission of British Columbia and billed by or for me in an approved claim format bearing my personal practitioner number, _____,
Practitioner Number, and the assignee's Payment Number _____,
Service Contract Payment Number

The Commission is hereby authorized to pay all such sums directly to Payment Number _____,
Service Contract Payment Number

at any address the Assignee may from time to time designate, with payment of any such sum to be sufficient discharge to the Commission of and from any indebtedness in that amount to the Assignor, his/her heirs, executors, or administrators.

THIS AGREEMENT is to remain in full force and effect for all claims submitted with Assignees Payment Number, _____,
Service Contract Payment Number, and my Personal Practitioner Number, _____,
Practitioner Number

from _____ to _____,
Effective Date (Month / Day / Year) Cancel Date (Month / Day / Year)

I will submit written notification to the Commission of the cancellation of this assignment should the cancellation precede the date specified above.

Dated this _____ day of _____, 20 ____.

_____,
Signature of ASSIGNOR (PHYSICIAN)

_____,
Signature of WITNESS

Mailing Address:
Provider Programs, PO Box 9480 Stn Prov Govt, Victoria BC V8W 9E7
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