



MEDICAL SERVICES PLAN (MSP) APPLICATION TO CANCEL OR CHANGE DETAILS FOR FACILITIES WITH AN MSP FACILITY NUMBER

To be completed by an applicant to cancel an MSP facility number OR change details of an MSP Facility Number.

All information on this form must be authorized by the responsible practitioner (the "Administrator"). If there are any changes to the information in this form after it has been submitted, a new form must be completed and submitted by the Administrator.

Complete Parts A and G in all cases. Complete other parts as applicable.

PART A: ADMINISTRATOR AND FACILITY (REQUIRED)

Form section for Part A: Administrator and Facility. Fields include Administrator Last Name, Administrator First Name, MSP Facility Number, Facility or Practice Name, Contact Email (Optional), Contact Phone Number, and Contact Fax Number (Optional).

PART B: CHANGE OF FACILITY ADDRESS OR MAILING ADDRESS (IF APPLICABLE)

To change the address of the facility associated with an MSP Facility Number, provide the effective date of the address change, the previous address and the new address. (A change in the physical location of the facility may result in a new MSP Facility Number being issued for the facility and may also impact (1) eligibility for the Business Cost Premium; and (2) the Business Cost Premium amount payable.)

PREVIOUS FACILITY ADDRESS

Form section for Previous Facility Address. Fields include Facility Physical Address (Number and Street), City, Postal Code, and Contact Fax Number (Optional).

PREVIOUS MAILING ADDRESS

Form section for Previous Mailing Address. Fields include Facility Mailing Address (if different from physical address), City, and Postal Code.

NEW FACILITY ADDRESS

Form section for New Facility Address. Fields include Facility Physical Address (Number and Street), City, Postal Code, and Contact Fax Number (Optional).

NEW FACILITY MAILING ADDRESS

Form section for New Facility Mailing Address. Fields include Facility Mailing Address (if different from physical address), City, and Postal Code.

PART C: BUSINESS COST PREMIUM (IF APPLICABLE)

The Business Cost Premium applies to Eligible Fees claimed by Eligible Physicians for services that are provided in a community-based office that has been issued an MSP Facility Number. MSP Facility Numbers are issued to qualifying facilities, based on the physical location of the facility. Eligible Physicians are those practitioners who are responsible to pay for some or all of the lease, rental, or ownership costs of the community-based office that has been issued an MSP Facility Number. Eligible Physicians must apply to be attached to the MSP Number for a facility to claim the Business Cost Premium on Eligible Fees for services provided at that facility.

Form section for Business Cost Premium. Includes checkbox: 'The applicant requests that the BCP apply to Eligible Fees of Eligible Physicians attached to this facility.' and BCP Effective Date (YYYY / MM / DD).

Indicate below to cancel BCP enrolment or change the BCP effective/cancellation date.

Form section for BCP changes. Includes checkboxes for 'Cancel BCP', 'Change BCP effective date', and 'Change BCP cancellation date', each with a corresponding date field (YYYY / MM / DD).

**PART D: CHANGE RESPONSIBLE ADMINISTRATOR (IF APPLICABLE)**

Administrator Last Name	Administrator First Name	MSP Practitioner Number
Effective Date of Change (YYYY/MM/DD)	Contact Email (Optional)	Contact Phone Number

**PART E: CANCELLATION OF FACILITY NUMBER (IF APPLICABLE)**

To authorize cancellation of an MSP Facility Number	Cancellation Date (YYYY / MM / DD)
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**PART F: OTHER CHANGE OR REQUEST (IF APPLICABLE)**

Administrators may request other changes or provide additional information associated with an MSP Facility Number not included in the standard fields provided in this form, including where a prior Eligible Physician is no longer providing services at this facility for which the Business Cost Premium on Eligible Fees would otherwise be paid. Requests in this field may be manually entered by HIBC against the MSP Facility Number, following which the Administrator will be notified of any such changes.

**PART G: DECLARATION AND ADMINISTRATOR SIGNATURE (REQUIRED)**

I understand that:

- i. this is a legal document and I represent that the information that I have provided on this document is true to the best of my knowledge;
- ii. MSP is a public system based on trust, but also that claims, including those portions relating to the Business Cost Premium, are subject to audit and financial recovery for claims made contrary to the *Medicare Protection Act* (the "Act"); and
- iii. submitting false or misleading claims information is an offence under the Act and may be an offence under the Criminal Code of Canada.

Signature of Administrator	Date Signed (YYYY / MM / DD)
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Personal information is collected under the authority of the *Medicare Protection Act* and section 26 (a), (c) and (e) of the *Freedom of Information and Protection of Privacy Act* for the purposes of administration of the Medical Services Plan. If you have any questions about the collection and use of your personal information, please contact the Health Insurance BC Chief Privacy Office at Health Insurance BC, Chief Privacy Office, PO Box 9035 STN Prov Govt, Victoria BC V8W 9E3 or call 604-683-7151 (Vancouver) or 1-800-663-7100 (toll free).