BRITISH COLUMBIA | Health InsuranceBC

MEDICAL SERVICES PLAN (MSP) PRACTITIONER ATTACHMENT TO MSP FACILITY NUMBER FOR BUSINESS COST PREMIUM

To be completed and submitted by an Eligible Physician (the "Practitioner") to add, change details of, or cancel the Practitioner's attachment to an MSP Facility Number for payment of the Business Cost Premium on Eligible Fees.

Eligible Physicians who intend to cancel their attachment to an MSP Facility Number and add an attachment to a new MSP Facility Number must complete and submit separate copies of this form.

Eligible Physicians must complete and submit this form to make changes to the effective date of attachments or cancellations previously submitted.

Practitioners may attach to more than one MSP Facility Number concurrently provided they qualify at each facility as an Eligible Practitioner. A separate form must be submitted for each MSP Facility Number that Eligible Physicians wish to attach to.

You must complete all parts of this form.

PART A: APPLICABLE FACILITY INFORMATION

Facility or Practice Name	MSP Facility Number

Facility Physical Address (Number and Street)	City	Postal Code

PART B: BUSINESS COST PREMIUM

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 this facility to claim the Business Cost Premium on Eligible Fees for services provided at this facility.

Practitioner Last Name	Practitioner First Name	MSP Practitioner Number

Contact Email (Optional)	Contact Phone Number	Contact Fax Number (Optional)

Indicate below if this form is being submitted to add a new attachment, cancel an existing attachment, or change an existing attachment

☐ Add New Attachment	New Attachment Effective Date (YYYY / MM / DD)	New Attachment Cancellation Date (Locum/Other Temp Attachment) (YYYY/MM/DD)
☐ Cancel Existing Attachment	Attachment Cancellation Date (YYYY / MM / DD)	
☐ Change Existing Attachment	Change Attachment Effective Date (YYYY / MM / DD)	Change Attachment Cancellation Date (if applicable) (YYYY / MM / DD)

PART C: DECLARATION AND PRACTITIONER SIGNATURE

I, the Practitioner named above, hereby confirm that: by checking either "Add New", "Cancel" above, or by requesting an "Other Change", I am either adding, changing details of, or cancelling an attachment to the MSP Facility Number set out in this document, as the case may be. In the case of adding an attachment or changing details of an attachment to the above MSP Facility Number:

i. I am an Eligible Physician regarding the facility that has been issued the MSP Facility Number named in this document, and that I understand that my claims for the Business Cost Premium on Eligible Fees will be based on my attachment to the MSP Facility Number named in this document;

ii. this attachment will result in the Business Cost Premium being applied to all Eligible Fees on claims submitted, in the format approved by the Medical Services Commission of British Columbia bearing my Practitioner Number and the MSP Facility Number of the facility named in this document;

iii. I understand that 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;

iv. I understand that claims in relation to the Business Cost Premium are subject to audit, and if found to be contrary to the *Medicare Protection Act* (the "Act"), are subject to financial recovery. I further understand that submitting false or misleading claims information is an offence under the Act and may be an offence under the Criminal Code of Canada;

v. I authorize the sharing of this information with the Administrator for the facility named in this document, including the delivery of this information to the facility mailing address for the purposes of confirmation of my attachment to the MSP Facility Number; and

vi. If, at any point, I am no longer an Eligible Physician with regard to the facility named in this document, I will submit a form for cancellation of my attachment to this MSP Facility Number to Health Insurance BC.

Signature of Practitioner	Date Signed (YYYY / MM / DD)

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).

Mailing Address: Health Insurance BC, 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**