



**BRITISH
COLUMBIA**
The Best Place on Earth

Health
InsuranceBC

**MEDICAL SERVICES PLAN
APPLICATION FOR TELEPLAN SERVICE
OPTED-OUT PRACTITIONERS**

TYPE OF PRACTICE: SOLO ☐ CLINIC ☐

PRACTITIONER NAME

ADDRESS

CITY

POSTAL CODE

PHONE NO.

CONTACT PERSON

PHONE NO.

FOR MSP USE ONLY

USER ID: _____

DATA CENTRE NO.: _____

DEFAULT PASSWORD: _____

DATE PROCESSED: _____

TSO: _____

YOUR CURRENT MSP PAYMENT NUMBER

TELEPLAN CLAIM SUBMISSION INFORMATION

DATA CENTRE INFORMATION

NEW DATA CENTRE

JOINING EXISTING DATA CENTRE

RE-ACTIVATE PREVIOUS DATA CENTRE

NAME: _____

NAME: _____

NAME: _____

CONTACT: _____

DATA
CENTRE NO.: _____

DATA
CENTRE NO.: _____

SYSTEM

MAKE/MODEL OF COMPUTER: _____

☐ INT

MAKE/MODEL OF MODEM: _____

☐ EXT

SPEED: _____

SOFTWARE NAME: (must be MSP tested and approved) _____

VENDOR: _____ SUPPLIER: _____

TERMS AND CONDITIONS

NOTE:

- All claim information such as: Refusal/Messages/Electronic Remittance will be returned to the practitioner.
- It is the practitioner's responsibility to provide patients with payment/refusal information.
- Patient's signature on your clinical records or separate form is mandatory for each service provided.
- CHEQUES WILL BE FORWARDED TO THE ADDRESS SUBMITTED ON THE CLAIM RECORD.
- Submission of claims must be under your personal payment number.
- An application form is required for every payee number.

I HAVE READ AND UNDERSTAND THE REGULATIONS AND REQUIREMENTS FOR CLAIMS SUBMISSION.

APPLICANT'S SIGNATURE

DATE

Personal information on this form is collected under the authority of the *Medicare Protection Act* and will be used to process your application for electronic billing, planning and record keeping. This 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.

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