



BRITISH COLUMBIA

Ministry of Health Services
Medical Services Plan (MSP)

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APPLICATION FOR ADDITIONAL PAYMENT NUMBER

650405-3592

SECTION A: PERSONAL DATA

YOUR MSP PRACTITIONER NUMBER	CURRENT FULL NAME OR GROUP NAME
YOUR CURRENT MSP PAYMENT NUMBER(S)	
MAILING ADDRESS AND POSTAL CODE OF CURRENT MSP PAYMENT NUMBER	

SECTION B: REASON FOR REQUEST

1 <input type="checkbox"/> OPENING NEW OFFICE	NAME/ADDRESS, CITY AND POSTAL CODE
2 <input type="checkbox"/> ESTABLISHING GROUP OR COMMON PAYMENT NUMBER	ORGANIZATION/GROUP NAME
3 <input type="checkbox"/> INCORPORATING - ATTACH COPY OF APPROVAL LETTER FROM THE COLLEGE OF PHYSICIANS AND SURGEONS OF BC	
4 <input type="checkbox"/> DIAGNOSTIC FACILITY CERTIFICATE OF APPROVAL - ATTACH COPY OF APPROVAL LETTER	
5 <input type="checkbox"/> OTHER	REASON

SECTION C: PAYMENT

INDICATE THE TYPE OF PAYMENT MODALITY

FEE FOR SERVICE ALTERNATIVE PAYMENT PROGRAM CONTRACT CONTRACT THROUGH HEALTH AUTHORITY

OTHER - STATE REASON:

TO APPLY FOR DIRECT BANK PAYMENT FROM MSP BC, PLEASE ATTACH A BLANK VOID CHEQUE

SECTION D: WEB/TELEPLAN (IF APPLICABLE)

DATA CENTRE NUMBER (WHEN JOINING EXISTING SITE)

SECTION E

EFFECTIVE DATE OF ADDITIONAL PAYMENT NO. MM DD YYYY	RESPONSIBLE PRACTITIONER'S MSP NUMBER	TELEPHONE NUMBER (INCLUDE AREA CODE)	FAX NUMBER (INCLUDE AREA CODE)
NAME OF RESPONSIBLE PRACTITIONER (PRINT OR TYPE)		SIGNATURE OF RESPONSIBLE PRACTITIONER	
EMAIL ADDRESS			