This is a fill and print form

Health Insurance BC

*Your connection with Medical Services Plan and PharmaCare.*

# APPLICATION FOR TELEPLAN SERVICE

MAILING ADDRESS:
PLEASE PRINT YOUR NAME AND ADDRESS
CLEARLY INCLUDING POSTAL CODE

NAME

ADDRESS

CITY | POSTAL CODE | PHONE NO.

ORGANIZATION NAME (if different from above) | CONTACT PERSON

**FOR MSP USE ONLY**

USER ID: _____

DATA CENTRE NO.: _____

DEFAULT PASSWORD: _____

DATE PROCESSED: _____

TSO: _____

## TYPE OF FACILITY

☐ HOSPITAL ☐ PRACTITIONER ☐ SERVICE BUREAU ☐ VENDOR ☐ CLINIC

## TELEPLAN CLAIM SUBMISSION INFORMATION

### DATA CENTRE INFORMATION

| NEW DATA CENTRE | OR | JOINING EXISTING DATA CENTRE | OR | JOINING SERVICE BUREAU |
|---|---|---|---|---|
| NAME: _____ | | NAME: _____ | | NAME: _____ |
| CONTACT: _____ | | DATA CENTRE NO.: _____ | | DATA CENTRE NO.: _____ |

### SYSTEM

**HARDWARE**

MAKE/MODEL OF COMPUTER: _____

MAKE/MODEL OF MODEM: _____ ☐ INT ☐ EXT SPEED: _____

**BILLING/BUSINESS SOFTWARE (must be MSP tested and approved)**

SOFTWARE NAME: _____

VENDOR: _____ SUPPLIER: _____

I MAKE APPLICATION TO UTILIZE THE TELEPLAN CLAIMS SUBMISSION SERVICE WITH THE FULL UNDERSTANDING OF, AND AGREEMENT WITH, THE REGULATIONS TO THE ***MEDICAL SERVICE ACT.***

_____ _____

*APPLICANT'S SIGNATURE* *DATE*

_____

*MSP PAYEE NUMBER*

**NOTE: AN APPLICATION FORM IS REQUIRED FOR EVERY PAYEE NUMBER**

HLTH 2820 Rev. 2007/02/15

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