BRITISH COLUMBIA
The Best Place on Earth

Health InsuranceBC

APPLICATION FOR ADDITIONAL PAYMENT NUMBER

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	☐ OPENING NEW OFFICE	NAME/ADDRESS, CITY AND POSTAL CODE
2	☐ ESTABLISHING GROUP OR COMMON PAYMENT NUMBER	ORGANIZATION/GROUP NAME
3	☐ INCORPORATING - ATTACH COPY OF APPROVAL LETTER FROM THE COLLEGE OF PHYSICIANS AND SURGEONS OF BC	
4	☐ DIAGNOSTIC FACILITY CERTIFICATE OF APPROVAL - ATTACH COPY OF APPROVAL LETTER	
5	☐ 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			

Mailing Address: Provider Programs, PO Box 9480 Stn Prov Govt, Victoria BC V8W 9E7
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