



**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     SPEED: \_\_\_\_\_  
 EXT

**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**