BRITISH COLUMBIA | Health InsuranceBC

The Best Place on Earth

APPLICATION FOR MSP BILLING NUMBER (PHYSICIANS)

*To be completed by **new applicants** who do not have a valid MSP billing number, are registered with the BC College of Physicians and Surgeons and wish to obtain a Medical Services Plan billing number.*

1. PERSONAL INFORMATION

LEGAL NAME	SURNAME	GIVEN NAME (FIRST)	GIVEN NAME (SECOND)

DATE OF BIRTH	MM	DD	YYYY	☐ F ☐ M	CITIZENSHIP	***NOTE:*** *If non-Canadian, indicate your status in Canada and enclose a copy of your **Canadian Immigration Employment Authorization** form (IMM 11(02) and / or Landed Immigrant status papers.*

BUSINESS MAILING ADDRESS	CITY	POSTAL CODE

PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS

HOME ADDRESS (NUMBER AND STREET)	CITY	POSTAL CODE

PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS

2. EDUCATION AND CERTIFICATION

MEDICAL SCHOOL	DATE OF GRADUATION (MM / DD / YYYY)
ROYAL COLLEGE SPECIALTY	DATE OF CERTIFICATION (MM / DD / YYYY)
ROYAL COLLEGE SUB-SPECIALTY	DATE OF CERTIFICATION (MM / DD / YYYY)
NON ROYAL COLLEGE SPECIALTY	DATE OF CERTIFICATION (MM / DD / YYYY)
NON ROYAL COLLEGE SUB-SPECIALTY	DATE OF CERTIFICATION (MM / DD / YYYY)

3. REGISTRATION: COLLEGE OF PHYSICIANS AND SURGEONS OF BRITISH COLUMBIA

DATE OF REGISTRATION (MM / DD / YYYY)	COLLEGE ID # (CPSID)	RESTRICTIONS (IF ANY)

☐ **FULL LICENSE**	EFFECTIVE DATE (MM / DD / YYYY)	✓ *(one)* ☐ **TEMPORARY LICENSE** ☐ **EDUCATION**	EFFECTIVE DATE (MM / DD / YYYY)	CANCELLATION DATE (MM / DD / YYYY)

4. PAYMENT

INDICATE TYPE OF PAYMENT YOU WILL BE SEEKING (*✓ appropriate boxes)*

☐ HOSPITAL OR AGENCY FUNDED ☐ APB SALARIED OR SESSIONAL ☐ FEE FOR SERVICE ☐ OTHER *(specify):*

To apply for Direct Bank Payment from MSP BC, please attach a blank sample cheque.

5. SIGNATURE

Signature *Date*

The information collected on this form is collected under the authority of the *Medical Protection Act*. The information you provide will be used to process your application for a Medical Services Plan Billing number and for record keeping. All information provided will be used in a manner that complies with the terms of the *Freedom of Information and Protection of Privacy Act*.

If you have any questions about the collection and use of this information, please contact Provider Programs at one of the numbers below. This application may be faxed (see information below).

Mailing Address: Provider Programs, PO Box 9480 Stn Prov Govt, Victoria BC V8W 9E7
Tel: (Lower Mainland) 604 456-6950, (Rest of BC) 1 866 456-6950 FAX: 250 405-3592 Web: **www.hibc.gov.bc.ca**

HLTH 2991 Rev. 2010/01/08