BRITISH COLUMBIA

Ministry of Health and
Ministry Responsible for Seniors
MEDICAL SERVICES PLAN

APPLICATION FOR TELEPLAN SERVICE

FOR MSP USE ONLY

USER ID: _____

DATA CENTRE NO.: _____

DEFAULT PASSWORD: _____

DATE PROCESSED: _____

TSO: _____

CURRENT 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 _____

TYPE OF FACILITY

HOSPITAL ☐ PRACTITIONER ☐ SERVICE BUREAU ☐ APPROVED LABORATORY ☐ 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**