



A B C D PLEASE USE CAPITAL LETTERS ONLY

This form is to be used only for specific circumstances. You must select one of the following boxes below to be able to use this form:

- Four checkboxes for beneficiary types: backdated MSP, Premium Assistance, no valid BC Services Card, and interim coverage.

MSP pays for medically required services according to the Medical Services Commission Payment Schedule. All claims are subject to the MSP rules and regulations. For more information visit: http://www.health.gov.bc.ca/msp/infooben/faqs.html.

Please include an itemized statement and proof of payment. Claims must be submitted within 90 days of the date of service. In exceptional cases there will be consideration of claims over 90 days old.

Note: In certain circumstances practitioners are permitted to charge their patients directly. (For example: the patient does not present their BC Services Card/CareCard when service is provided). The practitioner may charge more for the service than MSP will reimburse. The patient can use this form to be reimbursed for their MSP portion. It is the patient's responsibility to pay the difference.

1 PATIENT INFORMATION

Form fields for patient information: PATIENT LEGAL LAST NAME, PATIENT LEGAL FIRST NAME, PATIENT LEGAL SECOND NAME, PERSONAL HEALTH NUMBER (PHN), BIRTHDATE (MM / DD / YYYY), DAYTIME PHONE NUMBER, APT / UNIT, STREET NUMBER, STREET NAME, CITY, PROV, POSTAL CODE.

2 CLAIMS INFORMATION

If you have receipts from more than one practitioner or facility submit separate forms for each.

Form fields for claims information: NAME OF MEDICAL PRACTITIONER OR FACILITY PROVIDING SERVICE, PHONE NUMBER, NAME OF REFERRING PHYSICIAN (IF APPLICABLE), PHONE NUMBER.

Table with 4 columns: CLAIM ITEM, DATE(S) OF SERVICE MM / DD / YYYY, FEE ITEM / TYPE OF SERVICE PROVIDED, AMOUNT. Contains 5 rows for claim items.

For more than 5 claims items for one practitioner or facility, please submit another sheet.

3 PATIENT SIGNATURE

Form fields for patient signature: SIGNATURE OF PATIENT, DATE SIGNED (MM / DD / YYYY).

Personal information on this form is collected under the authority of the Medicare Protection Act and will be used to determine if the procedure(s) performed is a benefit of the Medical Services Plan and to determine the amount payable in accordance with the Act, regulations and appropriate payment schedule.

