BRITISH COLUMBIA | Health InsuranceBC
The Best Place on Earth

APPLICATION FOR TELEPLAN SERVICE

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: Your Name		NAME:		NAME:
CONTACT: Your Phone Number		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: ClinicAid

VENDOR: Cloud Practice Inc SUPPLIER: Cloud Practice Inc

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

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**

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