Government of Newfoundland and Labrador
Department of Health and Community Services
Medical Services Division

PROVIDER REGISTRATION FORM

Please Print

IF YOU ARE:

New Registrant - complete all areas of this form.

Updating Your Current Registration Information - only complete areas where information has changed**. Provider Number** _____

PERSONAL INFORMATION

Surname			Given Name and Initial	
☐ Male ☐ Female	Date of Birth	Place of Birth	MINC Number	Social Insurance Number

PROFESSIONAL INFORMATION

Graduation Code (See Table 1 Attached)	Date of Graduation with Professional Degree	Professional Category (See Table 2 Attached) ☐ Medical ☐ Dental	
College of Physicians and Surgeons	Effective Date of License	Practice Start Date	Specialty For Which You Are Licensed To Practice (See Table 5 Attached)
Email Address		CMPA ID	

PRACTICE INFORMATION

☐ Solo ☐ Group	Activity Code (See Table 4 Attached)	Activity Start Date	Activity Stop Date
Street/P.O. Box		City/Town	
Province	Postal Code	Telephone Number **(709)**	

CORRESPONDENCE ADDRESS
(Only if different from Practice Address)

Street/P.O. Box		City/Town
Province	Postal Code	Telephone Number **(709)**

Please complete over >

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PAYMENT INFORMATION

In order for all payments to be processed by direct deposit, a copy of a void cheque or official, stamped statement from your banking institution is required. *Professional Medical Corporations will also require the associated Canada Revenue Agency Business Number to be included with the account details.

To whom do you Assign Your MCP Payments: ☐ Self ☐ Other*

Name of Other* _____ Identity # of Other _____

CRA Business number: _____

***Assignment of Payment Agreement form must be completed to assign payment to a 3rd party.**

I hereby declare and affirm that I understand the content of all forms signed pursuant to this registration as a provider of service under the Newfoundland Medical Care Insurance Act, and that all information provided by me to MCP for purposes of this registration is accurate and true.

I acknowledge having reviewed and understand all pertinent information in relation to this registration with MCP, and I agree to abide by all terms and conditions therein contained, which terms and conditions shall form part of this application.

I agree to abide by the Newfoundland Medical Care Insurance Act and Regulations as they apply to the Medical Care Program or Dental Health Program.

Date _____ Signature _____

MCP PROVIDER NUMBER

When all information is received and processed, a six (6) digit Provider Number will be forwarded to you by email. This Provider Number must be identified on all claims submitted to MCP.

Privacy Notice

Under the authority of the *Medical Care Insurance Act, 1999*, personal information is collected in order to administer the Medical Care Plan (MCP). This information is kept confidential and handled as required by the *Access to Information and Protection of Privacy Act* (ATIPP). Any questions or comments can be directed to Matthew Pinsent, Senior Manager of Medical Services, Department of Health and Community Services, at (709) 729-5693 or MatthewPinsent@gov.nl.ca.

Provider Registration, Medical Services Division
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www.gov.nl.ca/mcp