

PROVIDER REGISTRATION FORM

Please Print

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IF YOU ARE:

<p>A New Registrant - complete all areas of this form.</p>
<p>Updating Your Current Registration Information - only complete areas where information has changed. Provider Number _____</p>

PERSONAL INFORMATION

Surname		Given Name and Initial		
<input type="checkbox"/> Male <input type="checkbox"/> 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) <input type="checkbox"/> Medical <input type="checkbox"/> 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

<input type="checkbox"/> Solo <input type="checkbox"/> 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 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 _____

***Assignment of Payment Agreement
form must be completed to assign payment to a different provider.**

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* (ATIPPA). Any questions or comments can be directed to Brian Bennett, Manager of Physician Services, Department of Health and Community Services, at (709) 729-3148 or BrianDBennett@gov.nl.ca.

**Provider Registration, Physician Services Division
Department of Health and Community Services
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www.gov.nl.ca/mcp