Newfoundland Labrador

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 >

PROVIDER REGISTRATION FORM

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
Department of Health and Community Services
P.O. Box 8700
St. John's, Newfoundland, Canada, A1B 4J6
Telephone: (709) 729-3508
Facsimile: (709) 729-5238

www.gov.nl.ca/mcp

1.2 GUIDELINES FOR COMPLETION OF PROVIDER REGISTRATION FORM

Guidelines for Completion of MCP Provider Registration Form

All Providers	New providers and those registered previously, and subsequently terminated, must complete all ***non-shaded*** areas of the form.
Registration Changes	When submitting updated information, enter your provider number at the top of the form, your surname and given name, and complete only the areas where the information requires updating.
Shaded Areas	These areas are for MCP use only.

Personal Information

Surname	Enter the registrant's full surname containing each letter to block markings.
Given Name & Initial	Enter the registrant's first name and initial.
Male/Female	Check appropriate block to record registrant's gender.
Date of Birth	Enter the registrant's date of birth, in the order of year/month/day.
MINC Number	
S.I.N.	Enter the registrant's Social Insurance Number.

Professional Information

Grad Code	Enter the appropriate two digit code which can be obtained from Table 1 on page 3. This code is used to record the place of graduation that relates to the registrant's University of graduation. This refers to the basic Professional Degree and is not intended to include post graduate training resulting in specialty certification.
Grad Date	Enter the date of graduation from the University granting the basic Professional Degree. Enter the appropriate date in the order of year/month/day.
Professional Category	Enter the appropriate code which can be obtained from Table 2 on page 3. This code is used to designate the professional discipline of the registrant.
College of Physicians and Surgeons	Enter the licence number which was designated for the registrant by the Professional Board responsible.
Date of Registration with College	This is the date that the registrant achieved registration with the appropriate Professional Board. Enter the appropriate date in the order of year/month/day.
Practice Start Date	This is the date that the registrant anticipates that the actual practice of the Profession will begin and MCP claims will begin to be generated. Enter the appropriate date in the order of year/month/day.
Specialty Code	A specialty comprises an area of knowledge in addition to that for which the provider is certified by the College of Physician and Surgeons. If applicable, enter the appropriate code from Table 5 on page 4.

Practice Information

Practice Type	This indicates whether the registrant is to practice with a group or as a solo practitioner. Check appropriate block to record the practice type.
Activity Code	Enter the appropriate three digit code which can be obtained from Table 4 on page 3. This code is used to advise MCP of the nature of the practice in which the registrant will be engaging. If doing a locum tenens the attached "MCP Locum Documentation/Declaration" form must be completed

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1.2 GUIDELINES FOR COMPLETION OF PROVIDER REGISTRATION FORM (cont'd)

Activity Start Date	This is used to advise MCP of the date at which the designated activity is deemed to be effective. Enter the appropriate date in the order of year/month/day.
Activity Stop Date	This is the date that will mark the end of the designated activity. If known, enter the appropriate date in the order of year/month/day.
Specialty Start Date	This is the date that the specialty became effective. Enter the appropriate date in the order of year/month/day.
Specialty Stop Date	This is the date the registrant wishes recognition of the specialty to cease. Enter the appropriate date in the order of year/month/day.
Sub-Specialty Code	Enter the specialty for which certification has been granted. Code can be obtained from Table 3 on page 3.
Practice Address	This designates the address at which the registrant will normally and usually practise. Enter the address, including postal code, containing each letter to block markings.
Telephone	Enter the telephone number at which the registrant can be contacted.

Correspondence Information

Correspondence Address	All correspondence from MCP to the registrant will be sent to the practice address unless indicated otherwise by the entry of information in the "Correspondence Address" block. Correspondence will not be divided between the two addresses, but will be "all inclusive" to one address or the other.

Payment Information

To Whom Do You Assign Your MCP Payments	Self	>	If the registrant is to receive MCP payments for claims generated by the registrant check this block.
	Other	>	If any provider or institution, other than the registrant, is to receive MCP payments for claims generated by the registrant, enter the name of the provider or institution and complete the "Assignment of Payment Agreement" form on the reverse side of the Provider Registration form.
	Identity # of other	>	Enter the Identity Number of the provider or institution, other than the registrant, to whom or to which MCP payments are to be made for claims generated by the registrant. The provider or institution must be registered with MCP to receive assigned payments.

Electronic Deposit	To facilitate the electronic deposit of funds payable by MCP in response to claims submitted, the Bank Name, Branch No., Code No., and Account No., are required. This information can be found on the face of a standard cheque. Enter the appropriate bank information.
Declaration	***This should be dated and signed and the form sent to***:

Department of Health and Community Services
Provider Registration, Physician Services Division
Belvedere Property
P.O. Box 8700
St. John's, Newfoundland A1B 4J6

MCP Provider Number	When the information submitted has been verified and processed, a six digit provider number will be issued. This number will be inserted on the Provider Registration form and a copy of the form will be returned to the provider

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1.2 GUIDELINES FOR COMPLETION OF PROVIDER REGISTRATION FORM (cont'd)

TABLE 1 - GRADUATION CODES

01 = Memorial University of Newfoundland	29 = Caribbean/Central & South America - other	59 = Japan
02 = Dalhousie University	30 = United Kingdom	60 = Iran
03 = Université Laval	31 = Ireland (Republic)	61 = People's Republic of China
04 = Université de Sherbrooke	32 = Poland	62 = Kuwait
05 = Université de Montréal	33 = France	63 = Sri Lanka
06 = McGill University	34 = Italy	64 = Thailand
07 = University of Ottawa	35 = Romania	65 = Taiwan
08 = Queen's University	36 = Czechoslovakia	66 = North Korea
09 = University of Toronto	37 = Germany	67 = South Korea
10 = McMaster University	38 = U.S.S.R.	68 = Malaysia
11 = University of Western Ontario	39 = Spain	69 = Asia - other
12 = University of Manitoba	40 = Belgium	70 = Australia
13 = University of Saskatchewan	41 = Hungary	71 = New Zealand
14 = University of Alberta	42 = Greece	72 = Iraq
15 = University of Calgary	43 = Switzerland	79 = Oceania - other
16 = University of British Columbia	44 = Yugoslavia	80 = Egypt
17 = Unknown Ontario University	45 = Sweden	81 = South Africa
18 = Unknown Alberta University	46 = Croatia	82 = Libya
90 = Unknown Quebec University	47 = Norway	83 = Nigeria
19 = Unknown University within Canada	48 = Bosnia	84 = Zambia
20 = U.S.A.	49 = Europe - other	85 = Zimbabwe
98 = Unknown country outside Canada & U.S.A.	50 = India	86 = Algeria
21 = Mexico	51 = Saudi Arabia	87 = Morocco
22 = Jamaica	52 = Lebanon	88 = Zaire
23 = Venezuela	53 = Philippines	89 = Africa - other
24 = Argentina	54 = Pakistan/Bangladesh	91 = Ghana
25 = Brazil	55 = Syria	92 = Mali
26 = Chile	56 = Israel	93 = Somalia
27 = Cuba	57 = Vietnam	94 = Kenya
28 = Haiti	58 = Hong Kong	95 = North America - Others Bermuda, Saint Pierre & Miquelon and Greenland
		99 = Unknown

TABLE 2 - PROFESSIONAL CATEGORY

D	= Dental
M	= Medical

TABLE 3 – SUB-SPECIALTY CODES

010 = Cardiology	040 = Developmental Pediatrics
011 = Clinical Immunology and Allergy	041 = Pediatric Emergency Med
012 = Critical Care Medicine	042 = Neonatal–Perinatal Medicine
013 = Endocrinologist and Metabolism	043 = Pediatric–Hematology/Onc
014 = Gastroenterology	050 = Neuroradiology
015 = Geriatric Medicine	051 = Pediatric Radiology
016 = Hematology	060 = Forensic Pathology
017 = Infectious Disease	061 = Neuropathology
018 = Medical Oncology	070 = Thoraic Surgery
019 = Nephrology	071 = Vascular Surgery
020 = Palliative Medicine	072 = Colorectal Surgery
021 = Respirology	073 = Surgical Oncololgy
022 = Rheumatology	074 = Pediatric General Surgery
023 = Clinical Pharmacology	090 = Gynecologic Oncology
024 = Emergency Medicine	091 = Gynecologic Reproductive Endocrinolgy/Infertility
025 = Occupational Medicine	092 = Maternal–Fetal Medicine

TABLE 4 - ACTIVITY CODES

001	= Private Practice
011	= Private Practice Locum
021	= FFS Temporary Non-Replacement
100	= Full Time Teaching
101	= GFT - FFS
200	= Salaried
210	= Salaried Locum
300	= Salaried Resident
301	= FFS Resident
500	= Administration

1.2 GUIDELINES FOR COMPLETION OF PROVIDER REGISTRATION FORM (cont'd)

TABLE 5 - PROVIDER SPECIALTY CODES			
Code	Specialty	Code	Specialty
001	General Practice	044	Paediatric Endocrinologist
002	Anaesthetist	045	Paediatric Respirologist
004	Emergency Medicine Specialist	046	Paediatric Rheumatologist
006	Dermatologist	047	Paediatric Gastroenterologist
008	General Surgeon	048	Paediatric Oncologist
010	Cardiac Surgeon	049	Paediatric Nephrologist
011	Vascular Surgeon	050	Paediatric Immunologist
012	Thoracic Surgeon	051	Paediatric Haemotologist
013	Internist	052	Neonatologist
015	Cardiologist	053	Physical Medicine Specialist
016	Endocrinologist	055	Plastic Surgeon
017	Respirologist	057	Psychiatrist
018	Rheumatologist	059	Urologist
019	Gastroenterologist	061	General Dentist
020	Medical Oncologist	062	Oral Surgeon
021	Nephrologist	063	Orthodontist
022	Immunologist	064	Periodontist
023	Haemotologist	065	Pedodontist
024	Geriatric Medicine Specialist	066	Denturist
025	Medical Genetics Specialist	067	Pathologist
026	Nuclear Medicine Specialist	069	Radiologist
027	Infectious Disease Specialist	071	Optometrist
028	Neurologist	073	Dental Public Health
030	Neurosurgeon	074	Developmental Neurology
032	Gynaecologist	075	Developmental Paediatrician
034	Gynaecology Oncologist	076	Endodontist
035	Ophthalmologist	077	Radiation Oncologist
037	Orthopaedic Surgeon	080	Paediatric Surgeon
039	Otolaryngologist	081	Paediatric Internist
041	Paediatrician	082	Medical Officers of Health
043	Paediatric Cardiologist	089	Palliative Care

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1.3 ASSIGNMENT OF PAYMENT AGREEMENT

Newfoundland Labrador

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

MCP Assignment of Payment Agreement

Under the Newfoundland Medical Care Insurance Act, when payment for insured services rendered by a provider is assigned to another provider or institution, the Act requires that a formalized agreement exist between the parties concerned (Physicians and Fees Regulations, paragraph 10). Authorized signatures to this agreement will accomplish this requirement.

Under this agreement, the assignor (locum or associate, as appropriate) agrees to assign to the assignee (principal provider or institution, as appropriate) all monies paid by MCP on account of claims submitted to MCP for services rendered by the locum or associate, whether submitted by the assignor or assignee. For good consideration, both the assignee and the assignor shall be jointly and severally liable to MCP for any recoveries of monies due to MCP and related services performed by the assignor.

This is to certify that:

A payment agreement, effective from _____ to _____
(Date) *(Date)*

exists between Dr. _____ _____
(Locum or Associate) *(Provider Number)*

and _____ _____
(Principal Provider or Associate) *(Provider or Institution Number)*

and that both parties to the agreement agree that:

1. Payment by MCP for claims generated by the locum or associate, who must be identified on the claim, will be made to the principal provider or institution from the date of this agreement.
2. Authorized signatures for claims from the principal provider or institution are acknowledged as authorized by the locum or associate.
3. The principal provider or institution and the assignor accept joint responsibility for the accuracy and validity of all information entered on claims submitted to MCP under this agreement.
4. This agreement shall be cancelled by MCP upon receipt of written notice duly signed by either party to the agreement.

Signed _____ Date _____
(Assignor)

Signed _____ Date _____
(Principal Provider or Institution)

Belvedere Site, P.O. Box 8700, St. John's, NL, Canada A1B 4J6 t 709.729-3508 f 709.729.5238

1.4 ELECTRONIC BILLING APPLICATION

Newfoundland Labrador

Government of Newfoundland and Labrador
Department of Health and Community Services
Medical Care Plan

mcp

Electronic Billing Application

SECTION A – All Providers Please Complete

Provider Name _____ Provider Number _____

Clinic Or Group Name (if applicable) _____

Street / P.O. Box _____

City / Town _____ Province _____ Postal Code _____

Telephone Number _____ Cell Phone Number _____ Fax Number _____

Electronic Billing Contact Person _____ Phone Number During Business Hours _____

If you are set up at another billing location and you require your electronic remittance and TADs to go there, please list the provider names and provider billing numbers of that location.

_____

_____

SECTION B – To Be Added To An Existing Electronic Billing Location

Your Claim Type: ☐ Medical ☐ Dental ☐ Both

Provider names and provider billing numbers at existing location:

_____

_____

Claims preparation software being used at existing location:

Software Name: Vendor Name:

SECTION C – Software Request

Windows Operating System on computer where software will be installed: _____

For Claims Preparation: ☐ TeleClaim (MCP's Electronic Billing Package) Your Claim Type: ☐ Medical ☐ Dental ☐ Both

If you will be using claims preparation software other than TeleClaim, please supply the following information:

Software Name: _____ Vendor Name: _____

For Data Transmission: ☐ MCP's Electronic Transmission Software Package

Please note that you must use a dial up modem for data transmission, and not, for example, a digital or cable modem.

Provider's Signature: _____ Date: _____

Medical Care Plan
22 High Street, P. O. Box 5000
Grand Falls-Windsor NL Canada A2A 2Y4
Tel: 1-800-563-1557 Fax: 709-292-4052

http://www.gov.nl.ca/mcp

Medical Care Plan
57 Margaret's Place, P. O. Box 8700
St. John's NL Canada A1B 4J6
Tel: 1-800-563-1557 Fax: 709-758-1691

November, 2006

1.5 MCP LOCUM DOCUMENTATION/DECLARATION

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

MCP Locum Documentation/Declaration

Terms of Reference

1. A physician, before undertaking a locum tenens, will supply in writing to MCP, the name and practice address of the physician(s) being replaced, along with the start and finish dates for the period of replacement.

2. Unless directed otherwise, the provider number of the physician(s) being replaced will be inactivated and claims will not be accepted during the time of the locum replacement. Physicians planning to submit claims anytime during the period of locum replacement must indicated so in the Comments section below.

To be completed, signed and returned to MCP before commencement of the locum arrangement

Name of Practice Physician: _____
(Please Print)

MCP Provider Number: _____

Practice Address: _____

Name of Locum Physician: _____
(Please Print)

MCP Provider Number: _____

Locum Start Date: _____

Locum Finish Date: _____

_____ _____
Signature of Practice Physician Date

_____ _____
Signature of Locum Physician Date

COMMENTS

Belvedere Site, P.O. Box 8700, St. John's, NL, Canada A1B 4J6 t 709.729-3508 f 709.729.5238

1.6 REQUEST FOR RELEASE OF MCP BENEFICIARY NUMBER

Newfoundland Labrador

Government of Newfoundland and Labrador
Department of Health and Community Services

Request for Release of Beneficiary MCP Number

Section 1	PATIENT'S PERSONAL INFORMATION		
Surname		Given Name and Initials	
Maiden Name (if applicable)	Gender – M/F	Birth Date – Year/Month/Day	
P.O. Box/Street Address			
City/Town	Province	Postal Code	Phone Number

I agree to allow the Newfoundland and Labrador Medical Care Commission to release my MCP Number to the health care provider/facility show below.

Signature of Patient or Guardian _____ Date _____

A parent or guardian may sign for a child under 16 years of age. A person holding power of attorney may sign for the represented individual.

Section 2	PROVIDER/FACILITY
Provider Billing Number	Facility Number
Provider Name, Address, and Telephone Number	Facility Name, Address, and Telephone Number

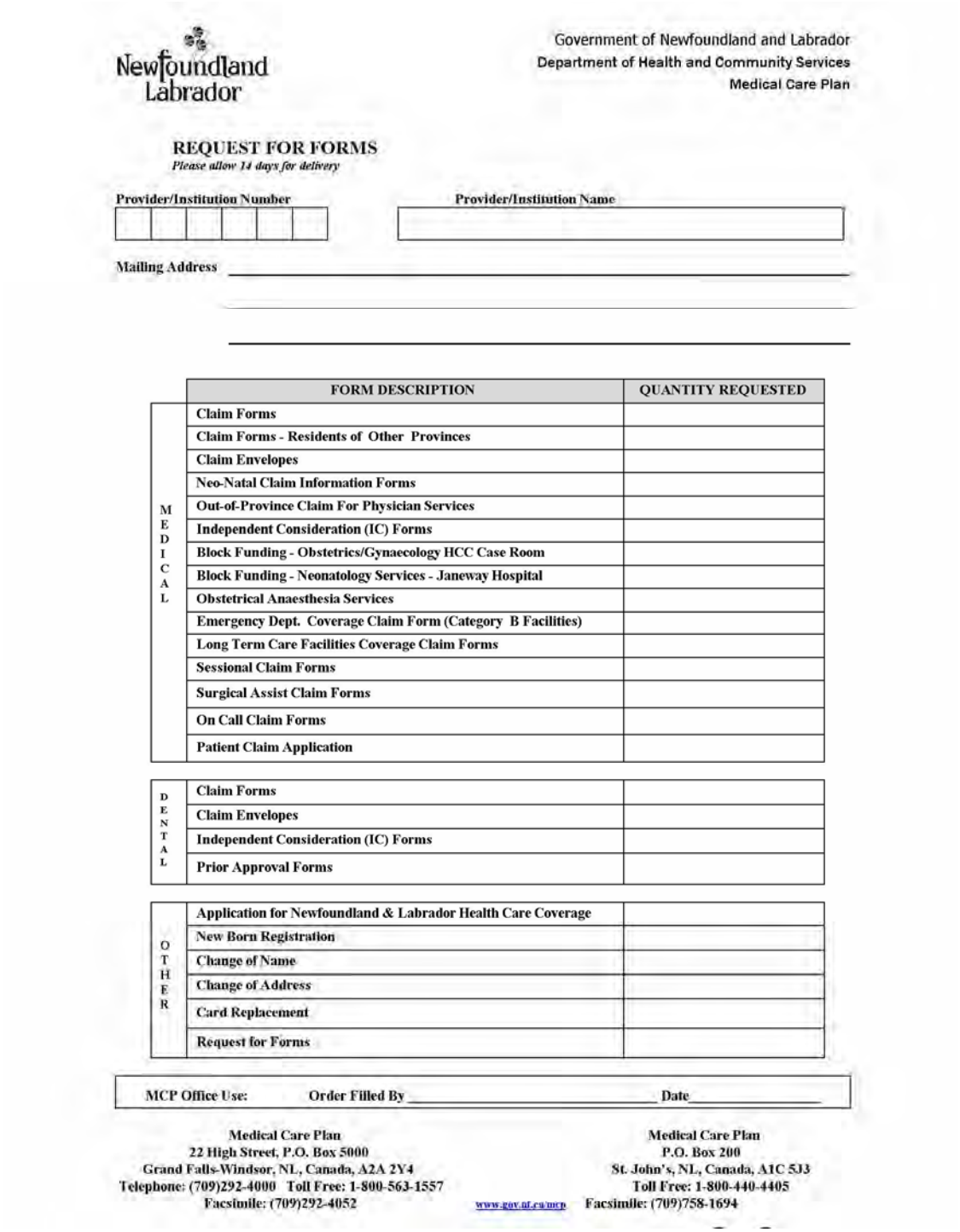
Signature of Provider or Designate _____ Signature of Authorized Facility Employee _____

Date _____ Date _____

Section 3	FOR MCP USE ONLY
	Patient's MCP Number

http:/www.gov.nl.ca/mcp

1.7 REQUEST FOR FORMS



Newfoundland Labrador

Government of Newfoundland and Labrador
Department of Health and Community Services
Medical Care Plan

REQUEST FOR FORMS
Please allow 14 days for delivery

Provider/Institution Number | **Provider/Institution Name**

Mailing Address _____

	FORM DESCRIPTION	QUANTITY REQUESTED
MEDICAL	Claim Forms	
	Claim Forms - Residents of Other Provinces	
	Claim Envelopes	
	Neo-Natal Claim Information Forms	
	Out-of-Province Claim For Physician Services	
	Independent Consideration (IC) Forms	
	Block Funding - Obstetrics/Gynaecology HCC Case Room	
	Block Funding - Neonatology Services - Janeway Hospital	
	Obstetrical Anaesthesia Services	
	Emergency Dept. Coverage Claim Form (Category B Facilities)	
	Long Term Care Facilities Coverage Claim Forms	
	Sessional Claim Forms	
	Surgical Assist Claim Forms	
	On Call Claim Forms	
	Patient Claim Application	
DENTAL	Claim Forms	
	Claim Envelopes	
	Independent Consideration (IC) Forms	
	Prior Approval Forms	
OTHER	Application for Newfoundland & Labrador Health Care Coverage	
	New Born Registration	
	Change of Name	
	Change of Address	
	Card Replacement	
	Request for Forms	

MCP Office Use: **Order Filled By** _____ **Date** _____

Medical Care Plan
22 High Street, P.O. Box 5000
Grand Falls-Windsor, NL, Canada, A2A 2Y4
Telephone: (709)292-4000 Toll Free: 1-800-563-1557
Facsimile: (709)292-4052

www.gov.nf.ca/mcp

Medical Care Plan
P.O. Box 200
St. John's, NL, Canada, A1C 5J3
Toll Free: 1-800-440-4405
Facsimile: (709)758-1694

2. FORMS FOR BENEFICIARIES

2.1 APPLICATION FOR NEWFOUNDLAND & LABRADOR HEALTH CARE COVERAGE

Newfoundland Labrador

Government of Newfoundland and Labrador
Department of Health and Community Services
mcp

APPLICATION FOR NEWFOUNDLAND & LABRADOR HEALTH CARE COVERAGE
Please read the back of this Application for important registration information

FOR OFFICE USE ONLY
Eligi. Dt Term. Dt

SECTION A **ANSWER ALL OF THE FOLLOWING QUESTIONS (*please print*)**

1. Have you or your dependents been registered with MCP before? ☐ **Yes** ☐ **No**
   If YES, please list on a separate sheet the previous MCP numbers (if available) of all persons to be registered.
2. When did you arrive in Newfoundland & Labrador? _____
3. Why did you move to Newfoundland & Labrador? ☐ **Work** ☐ **Study** ☐ **Other** _____
4. How long do you intend to stay in Newfoundland & Labrador? _____
5. Are any of the people being registered a member of: ☐ **Canadian Armed Forces** ☐ **NATO Forces** ☐ **RCMP**
   (Check one - if not applicable, leave blank)
6. Have all of your dependents moved with you to Newfoundland & Labrador? ☐ **Yes** ☐ **No**
   If NO, please explain _____
7. Are you moving to Newfoundland & Labrador from another part of Canada? ☐ **Yes** ☐ **No**
   If YES, which province or territory? _____
8. Are you moving to Newfoundland & Labrador from outside Canada? ☐ **Yes** ☐ **No**
   If YES, which country? _____

SECTION B **MAILING ADDRESS**

Street/P.O. Box		City/Town
Province	Postal Code	Telephone Number

SECTION C **MARITAL STATUS**

Single ☐	Married ☐	Widowed ☐	Divorced ☐	Separated ☐	Common Law ☐

SECTION D **LIST BELOW YOUR NAME AND THE NAMES OF ALL PERSONS REGISTERING FOR HEALTH CARE COVERAGE**
(attach a separate sheet if more space required)

Surname	All Given Names	Maiden Name (if applicable)	Sex (M/F)	Birth Date (YY/MM/DD)	Previous Province Health Insurance No.

SECTION E **DECLARATION**
(It is an offense to give false information for the purpose of obtaining coverage under the Newfoundland & Labrador Medical Care Plan)

I hereby declare that the information given is correct and the person(s) listed on this form are residents of Newfoundland & Labrador.

Signature Date

APPLICATION FOR NEWFOUNDLAND & LABRADOR HEALTH CARE COVERAGE

2.1 APPLICATION FOR NEWFOUNDLAND & LABRADOR HEALTH CARE COVERAGE (cont'd)

Newfoundland Labrador

Government of Newfoundland and Labrador
Department of Health and Community Services
mcp

PLEASE READ THE FOLLOWING INFORMATION *BEFORE* COMPLETING THE APPLICATION FOR NEWFOUNDLAND & LABRADOR HEALTH CARE COVERAGE

If you are applying for coverage with the Newfoundland & Labrador Medical Care Plan (MCP) for the first time, you must complete this form. If you are only applying for coverage for a newborn or adopted child, please complete the Newborn/Adopted Child Registration form instead.

DOCUMENTS YOU MUST SUBMIT WITH THIS APPLICATION

Applicants moving to Newfoundland & Labrador *from another part of Canada* must attach a copy of one of the following as proof of Canadian Citizenship:

- Social Insurance Card
- Unexpired Canadian Passport
- Canadian Birth Certificate
- Official Federal Government Identity Card or Federal Government document containing the Social Insurance Number and Name.

Applicants moving to Newfoundland & Labrador *from outside Canada* must attach a copy of official Immigration Documents for each person being registered.

Other documents may be requested by us to verify identity or eligibility. Please consult our information brochures or check with our office for more information on the documents you may need to submit. Original documents or good quality photocopies are acceptable. We will return your original documents after processing your application.

INELIGIBLE APPLICANTS

The following persons are not eligible for MCP coverage:

- Tourists, transients, and visitors
- Members of the RCMP, Canadian Armed Forces, or NATO Forces
- Inmates of federal prisons
- Certified refugees or refugee claimants
- Foreign students with student Visas

WAITING PERIOD

If you are moving to Newfoundland & Labrador from another province or territory, you will be covered by your previous Plan for the remainder of the month you arrived in Newfoundland & Labrador, plus two additional months. In order to allow sufficient time for a smooth change in coverage from your previous Plan to MCP, you should apply for coverage with MCP immediately upon arrival in Newfoundland & Labrador.

HEALTH CARE CARDS

If accepted for coverage, each person listed on the application will receive an MCP identity number and card. Keep the card with you at all times and present it each time you require medical services. A child's card should be entrusted to an adult for safekeeping. Contact MCP if your card becomes lost, stolen, damaged, or destroyed. Card replacement forms are also available at doctors' offices and hospitals throughout the province.

There are no charges or fees for MCP cards.

IT IS IMPORTANT THAT YOU NOTIFY MCP OF CHANGES TO YOUR NAME, ADDRESS, OR RESIDENCY STATUS

2.2 NEWBORN/ADOPTED CHILD REGISTRATION FORM

Newfoundland Labrador

Government of Newfoundland and Labrador
Department of Health and Community Services
mcp

NEWBORN / ADOPTED CHILD REGISTRATION FORM
Please Print

MAILING ADDRESS

Street/P.O. Box		City/Town	
Province	Postal Code	Telephone Number (Home)	Telephone Number (Work)

INFORMATION FOR PARENT OR GUARDIAN OF CHILD BEING REGISTERED

MCP Registration Number	Surname	All Given Names	Birth Date (YY/MM/DD)

CHILD/CHILDREN TO BE REGISTERED

Surname	All Given Names	Sex (M/F)	Birth Date (YY/MM/DD)

DECLARATION (it is an offence to give false information for the purpose of obtaining coverage under the Newfoundland & Labrador Medical Care Plan)

I hereby declare that the information given is correct and the person(s) listed on this form are residents of Newfoundland & Labrador.

Signature Date

REQUIRED DOCUMENTATION

If registering a child/children through adoption, a copy of the official adoption papers, or the birth certificate in the child's new name, is required for each child.

If the surname of the child/children is different than that of the registering parent or guardian, a copy of the birth certificate is required for each child.

Medical Care Plan
22 High Street, P.O. Box 5000
Grand Falls-Windsor, NL, Canada, A2A 2Y4
Telephone: (709)292-4000 Facsimile: (709)292-4052

Toll Free: 1-800-563-1557
www.gov.nl.ca/mcp

Medical Care Plan
Belvedere Building, 57 Margaret's Place, P.O. Box 8700
St. John's, NL, Canada, A1B 4J6
Telephone: (709)758-1600 Facsimile: (709)758-1694

2.3 CHANGE OF NAME FORM

Government of Newfoundland and Labrador
Department of Health and Community Services
mcp

CHANGE OF NAME FORM
Please Print

REASON FOR NAME CHANGE

MAILING ADDRESS

Street/P.O. Box		City/Town	
Province	Postal Code	Telephone Number (Home)	Telephone Number (Work)

DETAILS OF NAME CHANGE

MCP Registration Number		Previous Surname	Previous Given Names
Sex (M/F)	Birth Date (YY/MM/DD)	New Surname	New Given Names

DECLARATION (it is an offense to give false information for the purpose of obtaining coverage under the Newfoundland & Labrador Medical Care Plan)

I hereby declare that the information given is correct and the person(s) listed on this form are residents of Newfoundland & Labrador.

Signature Date

REQUIRED DOCUMENTATION

A copy of the Marriage Certificate is required for name changes due to marriage.

A copy of the official Certificate of Divorce, or Birth Certificate is required for name changes due to divorce.

A copy of the official Adoption Order, or Birth Certificate showing the new legal surname, is required for name changes due to adoption.

A copy of the legal name change document, or Birth Certificate showing the new legal name, is required for legal name changes.

Please return your old MCP card with this application.

Medical Care Plan
22 High Street, P.O. Box 5000
Grand Falls-Windsor, NL, Canada, A2A 2Y4
Telephone: (709)292-4000 Facsimile: (709)292-4052

Medical Care Plan
Belvedere Building, 57 Margaret's Place, P.O. Box 8700
St. John's, NL, Canada, A1B 4J6
Telephone: (709)758-1600 Facsimile: (709)758-1694

Toll Free: 1-800-563-1557
www.gov.nl.ca/mcp

2.4 CARD REPLACEMENT FORM

Government of Newfoundland and Labrador
Department of Health and Community Services
mcp

CARD REPLACEMENT FORM
Replacement cards are provided free of charge
Please Print

REASON FOR REPLACEMENT

MAILING ADDRESS

Street/P.O. Box		City/Town	
Province	Postal Code	Telephone Number (Home)	Telephone Number (Work)

CARD REPLACEMENT FOR APPLICANT

MCP Registration Number	
Surname	Maiden Name (if applicable)
All Given Names	
Sex ☐ Female ☐ Male	Birth Date (YY/MM/DD)

CARD REPLACEMENT FOR AN ADDITIONAL FAMILY MEMBER

MCP Registration Number	
Surname	Maiden Name (if applicable)
All Given Names	
Sex ☐ Female ☐ Male	Birth Date (YY/MM/DD)

DECLARATION (it is an offense to give false information for the purpose of obtaining coverage under the Newfoundland & Labrador Medical Care Plan)

I hereby declare that the information given is correct and the person(s) listed on this form are residents of Newfoundland & Labrador.

Signature Date

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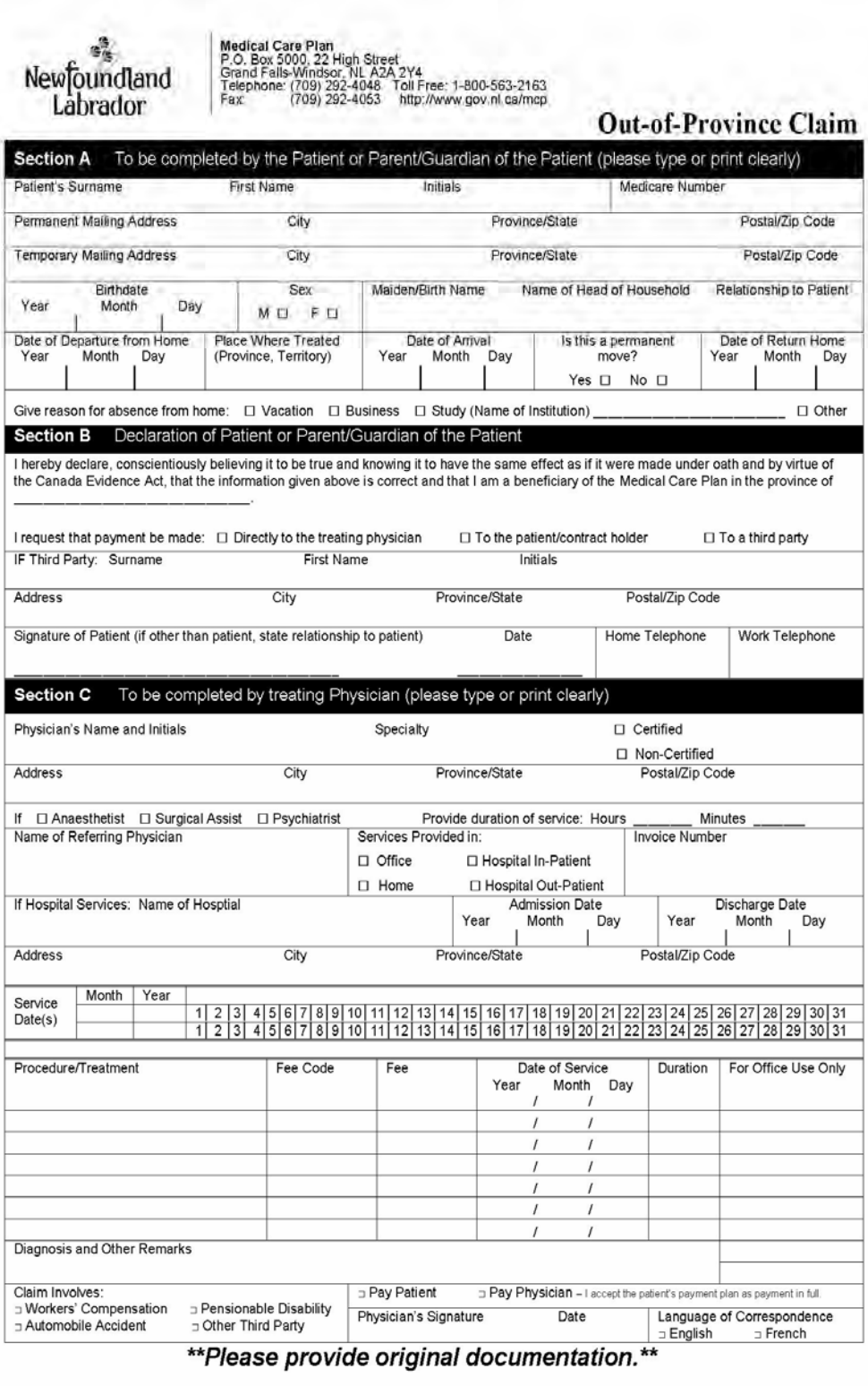
2.5 OUT-OF-PROVINCE CLAIM FORM



Newfoundland Labrador

Medical Care Plan
P.O. Box 5000, 22 High Street
Grand Falls-Windsor, NL A2A 2Y4
Telephone: (709) 292-4048 Toll Free: 1-800-563-2163
Fax: (709) 292-4053 http://www.gov.nl.ca/mcp

Out-of-Province Claim

Section A To be completed by the Patient or Parent/Guardian of the Patient (please type or print clearly)

Patient's Surname	First Name	Initials	Medicare Number

Permanent Mailing Address	City	Province/State	Postal/Zip Code

Temporary Mailing Address	City	Province/State	Postal/Zip Code

Birthdate Year Month Day	Sex M ☐ F ☐	Maiden/Birth Name	Name of Head of Household	Relationship to Patient

Date of Departure from Home Year Month Day	Place Where Treated (Province, Territory)	Date of Arrival Year Month Day	Is this a permanent move? Yes ☐ No ☐	Date of Return Home Year Month Day

Give reason for absence from home: ☐ Vacation ☐ Business ☐ Study (Name of Institution) _____ ☐ Other

Section B Declaration of Patient or Parent/Guardian of the Patient

I hereby declare, conscientiously believing it to be true and knowing it to have the same effect as if it were made under oath and by virtue of the Canada Evidence Act, that the information given above is correct and that I am a beneficiary of the Medical Care Plan in the province of _____.

I request that payment be made: ☐ Directly to the treating physician ☐ To the patient/contract holder ☐ To a third party

IF Third Party: Surname	First Name	Initials

Address	City	Province/State	Postal/Zip Code

Signature of Patient (if other than patient, state relationship to patient)	Date	Home Telephone	Work Telephone

Section C To be completed by treating Physician (please type or print clearly)

Physician's Name and Initials	Specialty	☐ Certified ☐ Non-Certified

Address	City	Province/State	Postal/Zip Code

If ☐ Anaesthetist ☐ Surgical Assist ☐ Psychiatrist Provide duration of service: Hours _____ Minutes _____

Name of Referring Physician	Services Provided in: ☐ Office ☐ Hospital In-Patient ☐ Home ☐ Hospital Out-Patient	Invoice Number

If Hospital Services: Name of Hosptial	Admission Date Year Month Day	Discharge Date Year Month Day

Address	City	Province/State	Postal/Zip Code

Service Date(s)	Month	Year	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
			1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Procedure/Treatment	Fee Code	Fee	Date of Service Year Month Day	Duration	For Office Use Only
			/ /		
			/ /		
			/ /		
			/ /		
			/ /		
			/ /		
			/ /		
Diagnosis and Other Remarks					

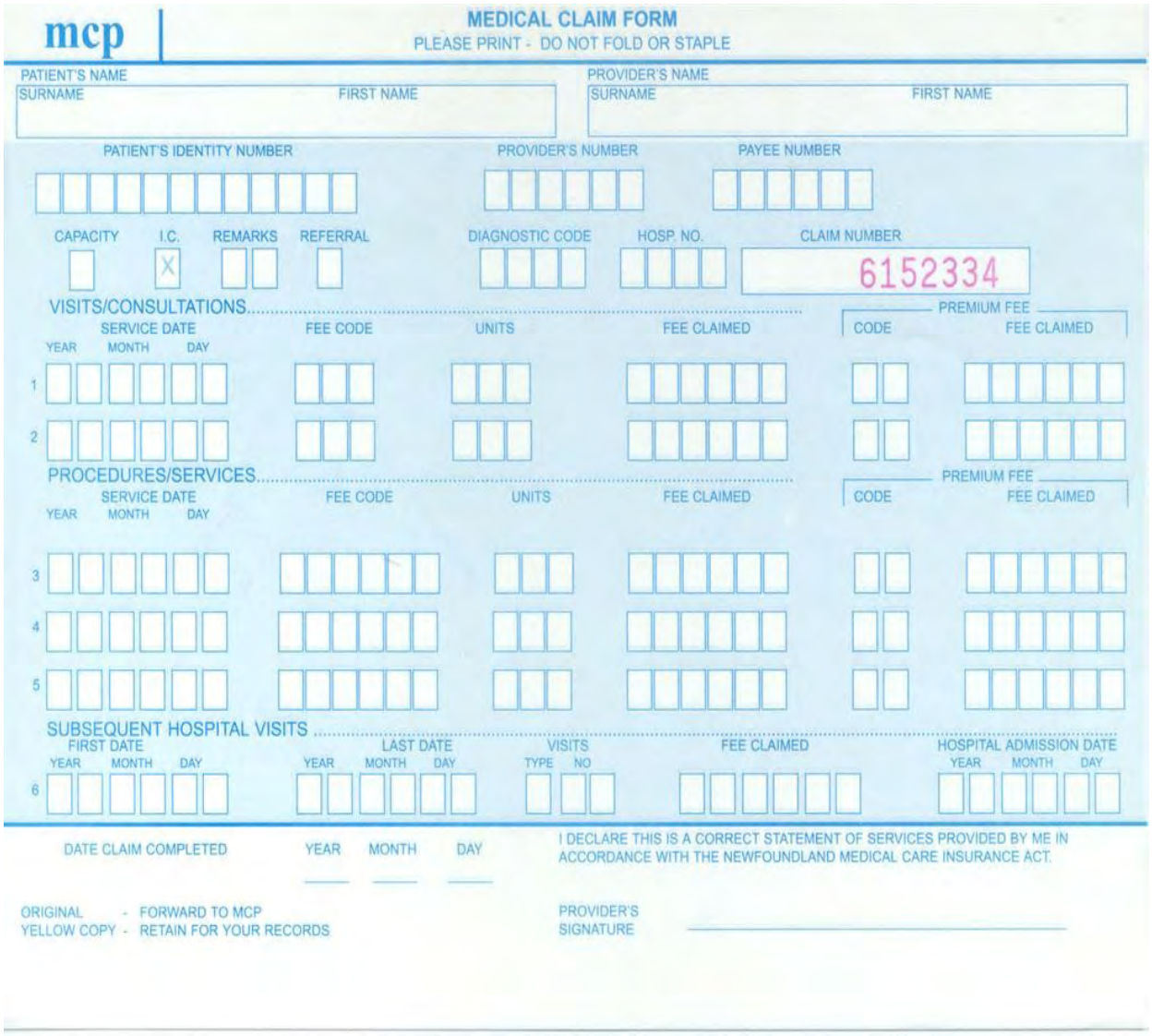
Claim Involves: ☐ Workers' Compensation ☐ Pensionable Disability ☐ Automobile Accident ☐ Other Third Party	☐ Pay Patient ☐ Pay Physician – I accept the patient's payment plan as payment in full. Physician's Signature Date	Language of Correspondence ☐ English ☐ French

Please provide original documentation.

3. PAPER CLAIM FORMS FOR PHYSICIAN BILLING

Paper claims are pre-numbered with a unique claim number and have carbon duplicates for physician records. Submitting claims on copies of the following sample claims is **not** permitted. Forms are available upon request from MCP at 1-800-563-1557, (709) 292-4000, or (709) 292-4015.

3.1 FEE-FOR-SERVICE MEDICAL CLAIM FORM



mcp

MEDICAL CLAIM FORM

PLEASE PRINT - DO NOT FOLD OR STAPLE

PATIENT'S NAME
SURNAME FIRST NAME

PROVIDER'S NAME
SURNAME FIRST NAME

PATIENT'S IDENTITY NUMBER

PROVIDER'S NUMBER

PAYEE NUMBER

CAPACITY I.C. REMARKS REFERRAL DIAGNOSTIC CODE HOSP. NO. CLAIM NUMBER

X

6152334

VISITS/CONSULTATIONS

SERVICE DATE YEAR MONTH DAY | FEE CODE | UNITS | FEE CLAIMED | PREMIUM FEE CODE | PREMIUM FEE FEE CLAIMED

1

2

PROCEDURES/SERVICES

SERVICE DATE YEAR MONTH DAY | FEE CODE | UNITS | FEE CLAIMED | PREMIUM FEE CODE | PREMIUM FEE FEE CLAIMED

3

4

5

SUBSEQUENT HOSPITAL VISITS

FIRST DATE YEAR MONTH DAY | LAST DATE YEAR MONTH DAY | VISITS TYPE NO | FEE CLAIMED | HOSPITAL ADMISSION DATE YEAR MONTH DAY

6

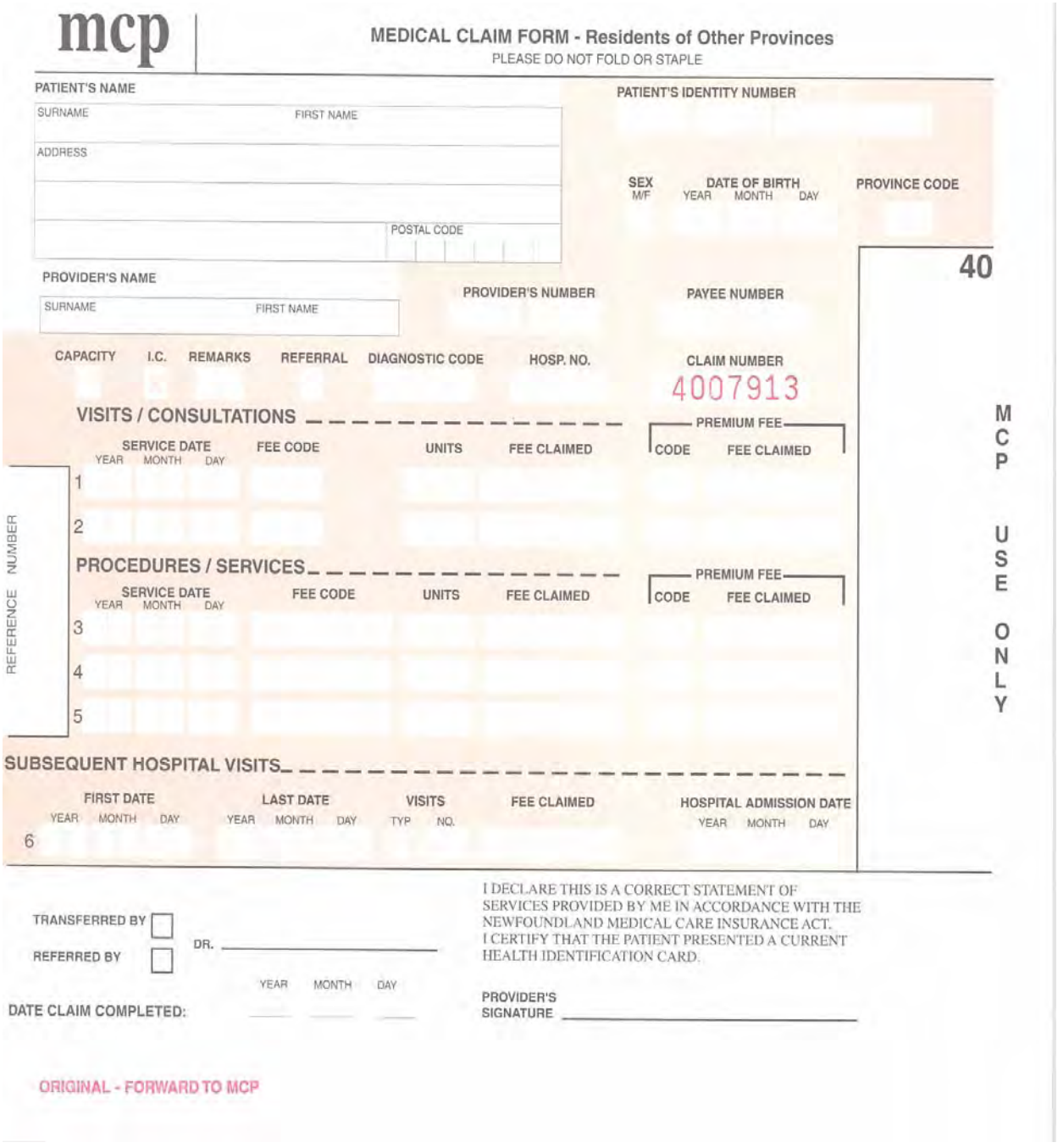
DATE CLAIM COMPLETED YEAR MONTH DAY

I DECLARE THIS IS A CORRECT STATEMENT OF SERVICES PROVIDED BY ME IN ACCORDANCE WITH THE NEWFOUNDLAND MEDICAL CARE INSURANCE ACT.

ORIGINAL - FORWARD TO MCP
YELLOW COPY - RETAIN FOR YOUR RECORDS

PROVIDER'S SIGNATURE

3.2 Fee-for-Service Medical Claim Form—Residents of Other Provinces



mcp

MEDICAL CLAIM FORM - Residents of Other Provinces

PLEASE DO NOT FOLD OR STAPLE

PATIENT'S NAME

SURNAME FIRST NAME

ADDRESS

POSTAL CODE

PATIENT'S IDENTITY NUMBER

SEX M/F DATE OF BIRTH YEAR MONTH DAY PROVINCE CODE

40

PROVIDER'S NAME

SURNAME FIRST NAME

PROVIDER'S NUMBER PAYEE NUMBER

CAPACITY I.C. REMARKS REFERRAL DIAGNOSTIC CODE HOSP. NO. CLAIM NUMBER

4007913

VISITS / CONSULTATIONS

SERVICE DATE YEAR MONTH DAY FEE CODE UNITS FEE CLAIMED PREMIUM FEE CODE FEE CLAIMED

1

2

PROCEDURES / SERVICES

SERVICE DATE YEAR MONTH DAY FEE CODE UNITS FEE CLAIMED PREMIUM FEE CODE FEE CLAIMED

3

4

5

REFERENCE NUMBER

SUBSEQUENT HOSPITAL VISITS

FIRST DATE YEAR MONTH DAY LAST DATE YEAR MONTH DAY VISITS TYP NO. FEE CLAIMED HOSPITAL ADMISSION DATE YEAR MONTH DAY

6

MCP USE ONLY

TRANSFERRED BY

REFERRED BY

DR.

I DECLARE THIS IS A CORRECT STATEMENT OF SERVICES PROVIDED BY ME IN ACCORDANCE WITH THE NEWFOUNDLAND MEDICAL CARE INSURANCE ACT. I CERTIFY THAT THE PATIENT PRESENTED A CURRENT HEALTH IDENTIFICATION CARD.

DATE CLAIM COMPLETED: YEAR MONTH DAY

PROVIDER'S SIGNATURE

ORIGINAL - FORWARD TO MCP

3.3 INDEPENDENT CONSIDERATION (IC) CLAIM FORM

Newfoundland Labrador

Government of Newfoundland and Labrador
Department of Health and Community Services
mcp

MEDICAL INDEPENDENT CONSIDERATION (IC) CLAIM FORM

Patient Identity Number	Patient Surname Given Name

Provider Number	Payee Number	Provider Capacity	Claim Number

Provider Surname Given Name

Important Note: The medical claim form accompanying this form must have the 'IC' field clearly marked 'X'. Omissions may cause incorrect payment.

Item Number	Date of Service			Specific or Comparable Fee Code	Units	Exact Time Involved		Fee Claimed
	Year	Month	Day			Hours	Minutes	

If claim is for escort, indicate time of departure and arrival at the hospital with the patient.

Time of Departure	Time of Arrival	Total Time

Reason for Claiming I.C.

Provider's Signature	Date

Submission procedures for Independent Consideration (I.C.) claims are specified in the Physician Information Manual.

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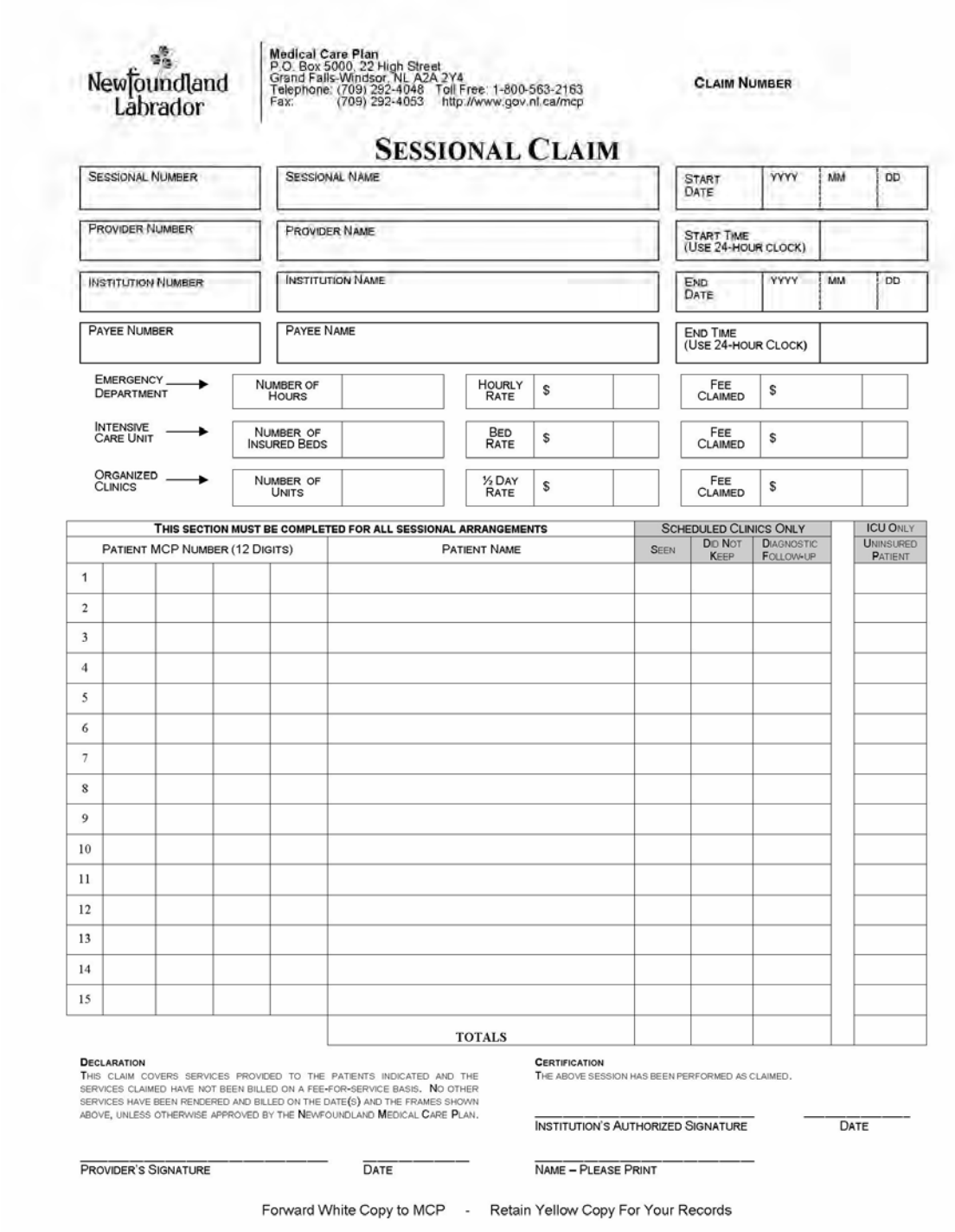
3.4 ALTERNATE BILLING ARRANGEMENTS CLAIM FORMS

3.4.1 Sessional—On-Site Emergency (Category A)/Organized Clinics/ICU



Newfoundland Labrador

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Fax: (709) 292-4053 http://www.gov.nl.ca/mcp

CLAIM NUMBER

SESSIONAL CLAIM

SESSIONAL NUMBER	SESSIONAL NAME	START DATE	YYYY	MM	DD
PROVIDER NUMBER	PROVIDER NAME	START TIME (USE 24-HOUR CLOCK)			
INSTITUTION NUMBER	INSTITUTION NAME	END DATE	YYYY	MM	DD
PAYEE NUMBER	PAYEE NAME	END TIME (USE 24-HOUR CLOCK)			

EMERGENCY DEPARTMENT →	NUMBER OF HOURS		HOURLY RATE	$	FEE CLAIMED	$
INTENSIVE CARE UNIT →	NUMBER OF INSURED BEDS		BED RATE	$	FEE CLAIMED	$
ORGANIZED CLINICS →	NUMBER OF UNITS		½ DAY RATE	$	FEE CLAIMED	$

THIS SECTION MUST BE COMPLETED FOR ALL SESSIONAL ARRANGEMENTS						SCHEDULED CLINICS ONLY			ICU ONLY
	PATIENT MCP NUMBER (12 DIGITS)				PATIENT NAME	SEEN	DO NOT KEEP	DIAGNOSTIC FOLLOW-UP	UNINSURED PATIENT
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
					TOTALS				

DECLARATION
THIS CLAIM COVERS SERVICES PROVIDED TO THE PATIENTS INDICATED AND THE SERVICES CLAIMED HAVE NOT BEEN BILLED ON A FEE-FOR-SERVICE BASIS. NO OTHER SERVICES HAVE BEEN RENDERED AND BILLED ON THE DATE(S) AND THE FRAMES SHOWN ABOVE, UNLESS OTHERWISE APPROVED BY THE NEWFOUNDLAND MEDICAL CARE PLAN.

PROVIDER'S SIGNATURE _____ DATE _____

CERTIFICATION
THE ABOVE SESSION HAS BEEN PERFORMED AS CLAIMED.

INSTITUTION'S AUTHORIZED SIGNATURE _____ DATE _____

NAME – PLEASE PRINT _____

Forward White Copy to MCP - Retain Yellow Copy For Your Records

3.4.2 Emergency Department Coverage—Category B Facilities

Newfoundland Labrador

Medical Care Plan
P.O. Box 5000, 22 High Street
Grand Falls-Windsor, NL A2A 2Y4
Telephone: (709) 292-4048 Toll Free: 1-800-563-2163
Fax: (709) 292-4053 http://www.gov.nl.ca/mcp

CLAIM NUMBER

EMERGENCY DEPARTMENT COVERAGE (CATEGORY B FACILITIES)

FEE CODE	SERVICE
611010	EMERGENCY DEPARTMENT COVERAGE
PROVIDER NUMBER	PROVIDER NAME
INSTITUTION NUMBER	INSTITUTION NAME
PAYEE NUMBER	PAYEE NAME

HOURLY RATE	$

* FOR START AND END TIMES, PLEASE USE 24-HOUR CLOCK. DO NOT USE AM/PM FORMAT.

	START DATE YY MM DD	START TIME (use 24-hour clock)	END DATE YY MM DD	END TIME (use 24-hour clock)	NUMBER OF HOURS	FEE CLAIMED
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

PROVIDER'S SIGNATURE OR AUTHORIZED SIGNATURE

DATE

ORIGINAL - SEND TO MCP COPY - RETAIN FOR RECORDS

3.4.3 Surgical Assist Claim—Dedicated Time Method

Newfoundland Labrador

Medical Care Plan
P.O. Box 5000, 22 High Street
Grand Falls-Windsor, NL A2A 2Y4
Telephone: (709) 292-4048 Toll Free: 1-800-563-2163
Fax: (709) 292-4053 http://www.gov.nl.ca/mcp

CLAIM NUMBER

SURGICAL ASSIST CLAIM

FEE CODE 631010	SERVICE SURGICAL ASSIST		START DATE	YYYY	MM DD
PROVIDER NUMBER	PROVIDER NAME		ACTUAL START TIME (Use 24-hour clock)		
INSTITUTION NUMBER	INSTITUTION NAME		ACTUAL END TIME (Use 24-hour clock)		
PAYEE NUMBER	PAYEE NAME		SCHEDULED START TIME (Use 24-hour clock)		
			SCHEDULED END TIME (Use 24-hour clock)		

NUMBER OF TIME UNITS		UNIT RATE	$	FEE CLAIMED	$
VISIT PREMIUM	PREMIUM CODE			PREMIUM CLAIMED	$
PROCEDURE PREMIUM	PREMIUM CODE			PREMIUM CLAIMED	$

THIS SECTION MUST BE COMPLETED

	PATIENT MCP NUMBER (12 DIGITS)	PATIENT NAME
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

DECLARATIONS:
NO SERVICES HAVE BEEN BILLED ON A FEE-FOR-SERVICE BASIS DURING THE TIME FRAME SHOW ABOVE.

Provider's Signature _____ Date _____

White Copy – Forward to MCP ◄► Yellow Copy – Retain for your records

3.4.4 Long Term Care Facility Coverage

Newfoundland Labrador

Medical Care Plan
P.O. Box 5000, 22 High Street
Grand Falls-Windsor, NL A2A 2Y4
Telephone: (709) 292-4048 Toll Free: 1-800-563-2163
Fax: (709) 292-4053 http://www.gov.nl.ca/mcp

CLAIM NUMBER

LONG TERM CARE FACILITY COVERAGE

FEE CODE	SERVICE
621010	LONG TERM CARE FACILITY COVERAGE
PROVIDER NUMBER	PROVIDER NAME
INSTITUTION NUMBER	INSTITUTION NAME
PAYEE NUMBER	PAYEE NAME

FACILITY RATE	$

* FOR START AND END TIMES, PLEASE USE 24-HOUR CLOCK. DO NOT USE AM/PM FORMAT.

	START DATE YY MM DD	START TIME (use 24-hour clock)	END DATE YY MM DD	END TIME (use 24-hour clock)	NUMBER OF 24 HOUR PERIODS	FEE CLAIMED
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

PROVIDER'S SIGNATURE OR AUTHORIZED SIGNATURE

DATE

ORIGINAL - SEND TO MCP COPY - RETAIN FOR RECORDS

3.4.5 Block Funding—Neonatology Services (Janeway Hospital)

Newfoundland Labrador

Medical Care Plan
P.O. Box 5000, 22 High Street
Grand Falls-Windsor, NL A2A 2Y4
Telephone: (709) 292-4048 Toll Free: 1-800-563-2163
Fax: (709) 292-4053 http://www.gov.nl.ca/mcp

CLAIM NUMBER

BLOCK FUNDING
NEONATOLOGY SERVICES – JANEWAY HOSPITAL

FACILITY NUMBER	PROVIDER NUMBER	PROVIDER NAME
0281		

PAYEE NUMBER	PAYEE NAME

* FOR START AND END TIMES, PLEASE USE 24-HOUR CLOCK. DO NOT USE AM/PM FORMAT.

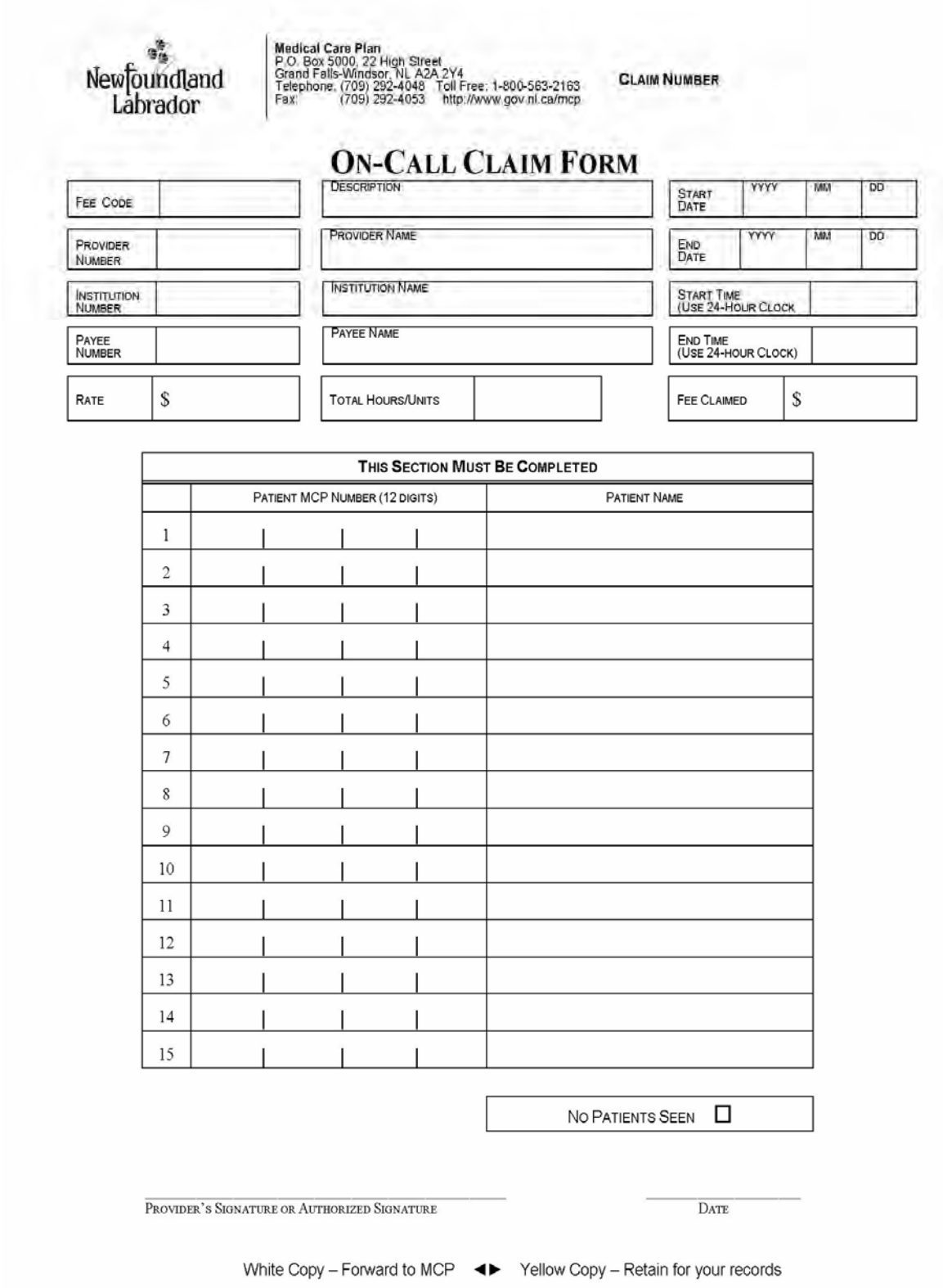
	FEE CODE	START DATE YY MM DD	START IME (use 24-hour clock)	END DATE YY MM DD	END TIME (use 24-hour clock)	NUMBER OF UNITS	FEE CLAIMED
1						1	
2						1	
3						1	
4						1	
5						1	
6						1	
7						1	
8						1	
9						1	
10						1	

PROVIDER'S SIGNATURE OR AUTHORIZED SIGNATURE

DATE

White Copy – Forward to MCP ◄► Yellow Copy – Retain for your records

3.4.6 On-Call Payment



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Fax: (709) 292-4053 http://www.gov.nl.ca/mcp

CLAIM NUMBER

ON-CALL CLAIM FORM

FEE CODE		DESCRIPTION		START DATE	YYYY	MM	DD
PROVIDER NUMBER		PROVIDER NAME		END DATE	YYYY	MM	DD
INSTITUTION NUMBER		INSTITUTION NAME		START TIME (USE 24-HOUR CLOCK)			
PAYEE NUMBER		PAYEE NAME		END TIME (USE 24-HOUR CLOCK)			
RATE	$	TOTAL HOURS/UNITS		FEE CLAIMED	$		

THIS SECTION MUST BE COMPLETED

	PATIENT MCP NUMBER (12 DIGITS)	PATIENT NAME
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		

NO PATIENTS SEEN ☐

PROVIDER'S SIGNATURE OR AUTHORIZED SIGNATURE

DATE

White Copy – Forward to MCP ◄► Yellow Copy – Retain for your records