Newfoundland Labrador

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

Electronic Billing Application

mcp

PLEASE COMPLETE ALL SECTIONS

SECTION A – General Information

Provider Name: ______________________________ Provider Number: ______________

Clinic / Group Name (if applicable): ______________________________

Street / P.O. Box: ______________________________

City / Town: ______________________ Province: __________ Postal Code: __________

Telephone Number: ______________ Cell Number: ______________ Fax Number: ______________

Electronic Billing Contact Person: ______________ Business Phone Number: ______________

Correspondence Email Address: ______________________________

SECTION B – Electronic Billing Site Information

Is this a new or existing electronic billing site? ____NEW ____ EXISTING

If NEW, please provide your start date for using this site: ______________________________

Your Claim Type: ___ MEDICAL ___ DENTAL ___ BOTH

If EXISTING, please provide two or three current Provider Names and Numbers or User Name (#), if known:

____

____

NOTE: Electronic Remittance and TAD files can be received by only one (1) billing site.

Should Remittance and TAD files be directed to this site? _______ YES _______ NO

SECTION C – Billing and Transmission Information

What version of Windows is / will be used on the billing computer (I.e. Windows 10): ______________________

Is this a request to change existing billing transmission or software or vendor? _______ YES _______ NO

Are you requesting (or currently using) MCP's TeleClaim software? _______ YES _______ NO

If **YES**, please provide a billing email address for the Secure File Transfer (SFT) Account:

Billing Email address: ______________________________

If **NO**, please provide the Software and / or the software Vendor name for the Electronic Billing program you will be using:

Software / Vendor Name: ______________________________

Billing Email address (if an SFT Account is required): ______________________________

Provider's Signature: ______________________________ Date: ______________

EMAIL OR FAX COMPLETED APPLICATION TO:
MCP Operations Email: mcp_operations@gov.nl.ca
Fax: 709-758-1583 **Tel:** 709-729-4357

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

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