BRITISH COLUMBIA | Ministry of Health

AUTHORIZATION FOR PAYMENT FROM MEDICAL SERVICES PLAN TO OPTED-OUT PRACTITIONERS

This form allows Dr. Bryan Friedmann to receive your Medical Services Plan (MSP) reimbursement directly for services that are MSP benefits. ***It is only valid if it is signed and dated (including the year) by both the patient and Dr. Bryan Friedmann.***

PATIENT INFORMATION AND AUTHORIZATION (PLEASE USE CAPITAL LETTERS)

Patient Last Name	Patient First Name	Patient Personal Health Number (PHN)

Patient Authorization

I, the patient named above, authorize MSP to pay the practitioner named below directly for reimbursements for benefits payable to me under the *Medical and Health Care Services Regulation* for care provided to me. I authorize the practitioner to collect MSP payment from the date when this form is signed to the end of the calendar year in which this form is signed.

For each service provided, the practitioner will notify me of the full fee and what portion of the fee they will claim directly from MSP.

- For optometry services MSP contributes an amount in accordance with the relevant payment schedule as set out by MSP.

I make this authorization in full knowledge that Dr. Bryan Friedmann will receive the full amount that is reimbursable to me from MSP for this service, and that I will not receive further reimbursement from MSP for any monies I have paid for this service (if applicable).

Patient Signature _____ Date Signed (dd/mm/yyyy) _____

PRACTITIONER INFORMATION AND DECLARATION (PLEASE USE CAPITAL LETTERS)

Practitioner Name	MSP Practitioner Number	MSP Payment Number
Dr. Bryan Friedmann	564	88080

Practitioner Declaration

I have advised the patient that this form allows me to receive MSP reimbursement directly for services that are MSP benefits, and that the patient will not receive further reimbursement from MSP. I acknowledge that all claims for services provided to this patient comply with the *Medicare Protection Act* and the relevant payment schedule. For each service provided, I will notify the patient of the full fee and what portion of the fee I will be claiming directly from MSP.

I understand that this authorization is only valid for the remainder of the calendar year in which it is signed, and that **the patient and I must complete a new Authorization for Payment from Medical Services Plan to Opted-Out Practitioners Form prior to directly billing MSP in future calendar years**. Further, I understand that eligible patients are only eligible for supplementary benefits for 10 claims per year for all supplementary services. As such, if the service relates to a supplementary benefit, I know that I will only receive reimbursement from MSP if the patient has eligible claims remaining for the year on the date of claim submission.

Practitioner Signature _____ Date Signed (dd/mm/yyyy) **Effective 01/01/2021-31/12/2021**

The information contained in this form is collected for the purposes of recordkeeping, claims administration and payment, and to otherwise administer and enforce the *Medicare Protection Act*. If this personal information is being collected by a private practitioner, the collection is occurring with your consent under the *Personal Information Protection Act*. Please speak with your practitioner or contact Health Insurance BC at the address or telephone numbers below if you have questions regarding the collection of your personal information.

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