BRITISH COLUMBIA
The Best Place on Earth

Health InsuranceBC

# APPLICATION FOR DIRECT BANK PAYMENT FROM MEDICAL SERVICES PLAN (MSP) or REQUEST FOR CHANGE OF BANKING INFORMATION

## PERSONAL DATA

Your MSP Payment Number

PAYMENT NUMBER

| | | | | |
|---|---|---|---|---|
| | | | | |

***(Note: Show either the GROUP or PHYSICIAN payment number)***

Surname or Group Name _____ Initials _____

*(Please Print)*

## AUTHORIZATION FOR DIRECT BANK PAYMENT FROM M.S.P.

*I hereby authorize MSP to make direct bank payment to me in the account indicated.*

_____ _____ _____

*Applicant's Signature* *Date* *Telephone*

Attach a blank sample cheque from the financial institute where you bank, make sure the cheque is fully MICRO-ENCODED with **BRANCH, INSTITUTION** and **ACCOUNT NUMBERS.**

## PAYMENT DATA

Branch Number

| | | | | |
|---|---|---|---|---|
| | | | | |

*(must be 5 digits)*

*Note: Payment Data will be used for Direct Bank Payment. Please be sure that all digits, including zeros, "0" are given.*

Institution Number

| | | |
|---|---|---|
| | | |

*(must be 3 digits)*

Account Number

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | |

Institution / Bank Name _____

Branch Name _____

Street Address _____

City _____ Province _____

Postal Code _____ Telephone _____

Mailing Address: Provider Programs, PO Box 9480 Stn Prov Govt, Victoria BC V8W 9E7
Tel: (Lower Mainland) 604 456-6950, (Rest of BC) 1 866 456-6950, Fax: 250 405-3592 Web: **www.hibc.gov.bc.ca**

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PRINT RESET