

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



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	e Postal Code
Telephone Number Cell	Phone Number	Fax Number
Electronic Billing Contact Person	Phone Nun	nber During Business Hours
If you are set up at another billing location and you renames and provider billing numbers of that location.	equire your electronic remitt	tance and TADs to go there, please list the provider
SECTION B – To Be Added To An Existing E	Electronic Billing Locati	on
Your Claim Type: G Medical G Dent	al G Both	
Provider names and provider billing numbers at exis	ting location:	
Claims preparation software being used at existing le	ocation:	
Software Name:	Vendor	Name:
SECTION C – Software Request		
Windows Operating System on computer where soft	ware will be installed:	
For Claims Preparation: G TeleClaim (MCP's Elec	ctronic Billing Package)	Your Claim Type: G Medical G Dental G Bot
If you will be using claims preparation software other	r than TeleClaim, please suլ	pply the following information:
Software Name: Vendor Name:		
For Data Transmission: G MCP's Electronic Tran	nsmission Software Package data transmission, and not, f	
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