



# 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: \_\_\_\_\_