Topic: The Critical Care Coverage Program

Date:

The Critical Care Coverage Program provides payment to physicians for providing **critical** services to residents of British Columbia who are not enrolled in MSP but would be eligible to receive MSP. (Note: Residents who have elected to opt out of MSP cannot be covered with this program.)

A resident of BC is defined as a person who meets the following conditions:

- A citizen or a permanent resident of Canada;
- Makes their home in BC; and
- Is physically present in BC at least 6 months of the calendar year.

Payment for services under this program will only be considered if the following two criteria are met:

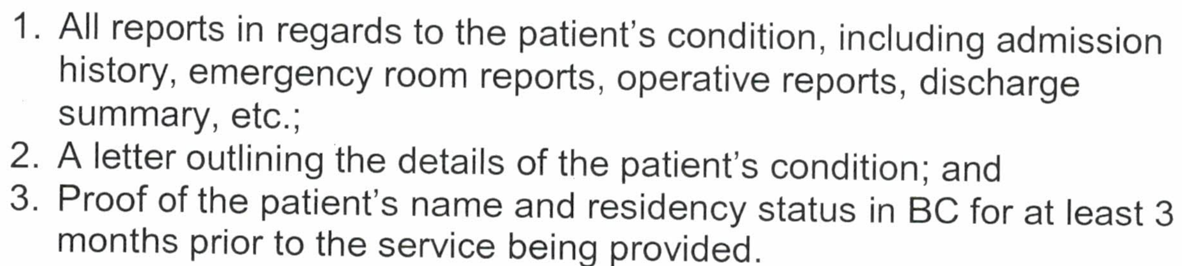
1. The patient must have been a resident of British Columbia for three months, and proof of residency must be provided when the application for payment is submitted. A proof of residency may include the following:
    - A utility bill in the patient's name from at least 3 months prior to the service being provided;
    - A letter from the patient's employer indicating residence of at least 3 months prior to the service being provided; or

- A letter from the police indicating that the patient has been known to them for at least 3 months prior to the service being provided.

2. The patient must present with **one** of the following medical conditions for which documentation is provided to MSP:
   - A medical condition that is immediately threatening to life or limb;
   - Unconsciousness;
   - An emergency condition that requires immediate admission to an intensive care unit (or equivalent); or
   - A required involuntary admission under the *Mental Health Act*.

Once the Critical phase of the patient's care is complete, Critical Care Coverage is no longer available.

Applications to MSP for payment under the Critical Care Coverage Program must be submitted using the Pay Practitioner form (HLTH 1917) and all of the following documentation:



1. All reports in regards to the patient's condition, including admission history, emergency room reports, operative reports, discharge summary, etc.;
2. A letter outlining the details of the patient's condition; and
3. Proof of the patient's name and residency status in BC for at least 3 months prior to the service being provided.

Mail all documentation listed above to the address listed at the bottom of the Pay Practitioner form with the form itself with the phrase “ATTENTION: Critical Care” written on the front of the envelope. While completing the Pay Practitioner form please note the following instructions:

- Omit the PHN and patient’s name fields at the top of the form;
- Write the phrase “Critical Care” at the top of the form;
- Record the name of the patient and the diagnosis in the box labelled “Type of Procedure or Operation;”
- Complete the rest of the form appropriately.

For further assistance or clarification in regards to Critical Care, please contact MSP Practitioner Claims Support at 1-866-456-6950.

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MEDICAL SERVICES PLAN (MSP)

PAY RECIPROCAL PRACTITIONER CLAIM

PR

CLAIMS MUST BE SUBMITTED WITHIN 90 DAYS

A B C D PLEASE USE CAPITAL LETTERS ONLY

PATIENT INFORMATION

PROVINCE/ TERRITORY

REGISTRATION NUMBER

PATIENT LEGAL FIRST NAME

SECOND NAME INITIAL

PATIENT LEGAL LAST NAME

GENDER

M

F

PATIENT BIRTHDATE (MM / DD / YYYY)

MVA RELATED?

YES

IF YES, MVA CLAIM NUMBER

CORRESPONDENCE ATTACHED

SUBMISSION CODE

APT / UNIT

STREET NUMBER

STREET NAME

CITY

PROVINCE

POSTAL CODE

SERVICE(S)

DATE OF SERVICE MONTH	DAY	YEAR	NO. OF SERVICES	S.C.C.	FEE ITEM	AMOUNT BILLED	TIME RENDERED CALLED START	FINISH	DIAGNOSTIC CODE	LOC. OF SERV.

HOSPITAL VISITS

DATE OF SERVICE MONTH	DAY FROM - TO	YEAR	NO. OF SERVICES	S.C.C.	FEE ITEM	AMOUNT BILLED	DIAGNOSTIC CODE	LOC. OF SERV.

DIAGNOSIS OR AREA OF TREATMENT

PRACTITIONER INFORMATION

PRACTITIONER LAST NAME OR CLINIC NAME

FIRST NAME INITIAL

PRACTITIONER SIGNATURE

PAYMENT NUMBER

PRACTITIONER NUMBER

REFERRED BY

PRACTITIONER NUMBER

REFERRED BY (PRACTITIONER LAST NAME)

FIRST NAME INITIAL

REFERRED TO

PRACTITIONER NUMBER

REFERRED TO (PRACTITIONER LAST NAME)

FIRST NAME INITIAL

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MEDICAL SERVICES PLAN (MSP)

PAY RECIPROCAL PRACTITIONER CLAIM

CLAIMS MUST BE SUBMITTED WITHIN 90 DAYS

A B C D PLEASE USE CAPITAL LETTERS ONLY

PATIENT INFORMATION

PROVINCE/ TERRITORY | REGISTRATION NUMBER

PATIENT LEGAL FIRST NAME | SECOND NAME INITIAL | PATIENT LEGAL LAST NAME

GENDER M F | PATIENT BIRTHDATE (MM / DD / YYYY) | MVA RELATED? YES | IF YES, MVA CLAIM NUMBER | CORRESPONDENCE ATTACHED | SUBMISSION CODE

APT / UNIT | STREET NUMBER | STREET NAME

CITY | PROVINCE | POSTAL CODE

SERVICE(S)

DATE OF SERVICE MONTH	DAY	YEAR	NO. OF SERVICES	S.C.C.	FEE ITEM	AMOUNT BILLED	TIME CALLED START	TIME RENDERED FINISH	DIAGNOSTIC CODE	LOC. OF SERV.

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DIAGNOSIS OR AREA OF TREATMENT

PRACTITIONER INFORMATION

PRACTITIONER LAST NAME OR CLINIC NAME | FIRST NAME INITIAL | PRACTITIONER SIGNATURE

PAYMENT NUMBER | PRACTITIONER NUMBER

REFERRED BY | PRACTITIONER NUMBER | REFERRED BY (PRACTITIONER LAST NAME) | FIRST NAME INITIAL

REFERRED TO | PRACTITIONER NUMBER | REFERRED TO (PRACTITIONER LAST NAME) | FIRST NAME INITIAL

Mailing Address: Health Insurance BC, Medical Services Plan, PO Box 9689 Stn Prov Govt, Victoria BC V8W 9P8
Tel: (Lower Mainland) 604 456-6950, (Rest of BC) 1 866 456-6950 Web: **www.hibc.gov.bc.ca**