Government of Newfoundland and Labrador
Department of Health and Community Services
Physician Services Division

PROVIDER REGISTRATION FORM

Please Print

IF YOU ARE:

A New Registrant - complete all areas of this form.

Updating Your Current Registration Information - only complete areas where information has changed**. Provider Number** _____

PERSONAL INFORMATION

Surname		Given Name and Initial		
☐ Male ☐ Female	Date of Birth	Place of Birth	MINC Number	Social Insurance Number

PROFESSIONAL INFORMATION

Graduation Code (See Table 1 Attached)	Date of Graduation with Professional Degree	Professional Category (See Table 2 Attached) ☐ Medical ☐ Dental	
College of Physicians and Surgeons	Effective Date of Licence	Practice Start Date	Specialty For Which You Are Licensed To Practice (See Table 5 Attached)
email address			

PRACTICE INFORMATION

☐ Solo ☐ Group	Activity Code (See Table 4 Attached)	Activity Start Date		Activity Stop Date
Termination Code	Termination Date	Spec Start Date	Spec Stop Date	Sub-specialty Code (See Table 3 Attached)
Street/P.O. Box		City/Town		
Province	Postal Code	Telephone Number **(709)**		

CORRESPONDENCE ADDRESS
(Only if different from Practice Address)

Street/P.O. Box		City/Town
Province	Postal Code	Telephone Number **(709)**

Please complete over >

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PAYMENT INFORMATION

In order for all payments to be deposited into your account please provide copy of a void cheque.

To whom do you Assign Your MCP Payments: ☐ Self ☐ Other*

Name of Other* _____ Identity # of Other _____

"Assignment of Payment Agreement" form must be completed.

I hereby declare and affirm that I understand the content of all forms signed pursuant to this registration as a provider of service under the Newfoundland Medical Care Insurance Act, and that all information provided by me to MCP for purposes of this registration is accurate and true.

I acknowledge having reviewed and understand all pertinent information in relation to this registration with MCP, and I agree to abide by all terms and conditions therein contained, which terms and conditions shall form part of this application.

I agree to abide by the Newfoundland Medical Care Insurance Act and Regulations as they apply to the Medical Care Program or Dental Health Program.

Date _____ Signature _____

MCP PROVIDER NUMBER:

When all information is received and processed, a copy of this form along with a six (6) digit Provider Number will be forwarded to you. This Provider Number must be identified on all claims submitted to MCP.

For Office Use Only

Date Keyed: _____ **Initials** _____ **NEW PROVIDER NUMBER:** _____

Board Information Date: _____

Provider Registration, Physician Services Division
57 Margaret's Place, P.O. Box 8700
St. John's, Newfoundland, Canada, A1B 4J6
Telephone: (709) 729-3508
Facsimile: (709) 729-5238

www.gov.nl.ca/mcp