COLLEGE OF OPTOMETRISTS OF BRITISH COLUMBIA

REQUEST FOR APPROVAL TO BILL MSP FOR LOW VISION & VISUAL FIELDS SERVICES

(Please complete, print and sign form)

If you have requested for multiple locations please complete a separate declaration for each location.

Place of Practice Location: _____

Address Line 1

_____

Address Line 2

_____ | _____

City, Province | Postal Code

Registrant Email Address: _____

MSP Practitioner Number: _____

MSP Payee Number:* _____

*If you have requested Assignment of Payment with MSP please provide the appropriate payee number here. Please complete a separate declaration for each payee number.

DECLARATION

(Please sign all declarations that apply)

I, Dr. _____ , Reg. No. _____, declare that I am qualified to provide:

(Print full name)

a) **VISUAL FIELDS SERVICES** and that I have access to and will employ computer-assisted quantitative instrumentation which is appropriate when billing for visual fields services, effective ___ / ___ / _____ .
DD MM YYYY

Signed: _____ **Dated:** _____

b) **LOW VISION SERVICES** and that I have access and will employ low vision instrumentation which is appropriate when billing for low vision services, effective ___ / ___ / _____ .
DD MM YYYY

Signed: _____ **Dated:** _____

RETURN COMPLETED FORM TO THE COLLEGE VIA FAX TO 604.623.3465

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