



MAILING ADDRESS:

PLEASE PRINT YOUR NAME AND ADDRESS CLEARLY INCLUDING POSTAL CODE

NAME		
ADDRESS		
CITY	POSTAL CODE	PHONE NO.
ORGANIZATION NAME (if different from above)		CONTACT PERSON

FOR MSP USE ONLY

USER ID: _____
DATA CENTRE NO.: _____
DEFAULT PASSWORD: _____
DATE PROCESSED: _____
TSO: _____

TYPE OF FACILITY

HOSPITAL
 PRACTITIONER
 SERVICE BUREAU
 VENDOR
 CLINIC

TELEPLAN CLAIM SUBMISSION INFORMATION

DATA CENTRE INFORMATION

NEW DATA CENTRE	OR	JOINING EXISTING DATA CENTRE	OR	JOINING SERVICE BUREAU
NAME: _____		NAME: _____		NAME: _____
CONTACT: _____		DATA CENTRE NO.: _____		DATA CENTRE NO.: _____

SYSTEM

HARDWARE

MAKE/MODEL OF COMPUTER: Hosted in Data Center. Intel I7-2600, 8GB RAM.

MAKE/MODEL OF MODEM: Hosted in Data Center
 INT SPEED: _____
 EXT

BILLING/BUSINESS SOFTWARE (must be MSP tested and approved)

SOFTWARE NAME: ClinicAid

VENDOR: Cloud Practice Inc SUPPLIER: Cloud Practice Inc

I MAKE APPLICATION TO UTILIZE THE TELEPLAN CLAIMS SUBMISSION SERVICE WITH THE FULL UNDERSTANDING OF, AND AGREEMENT WITH, THE REGULATIONS TO THE **MEDICAL SERVICE ACT**.

APPLICANT'S SIGNATURE

DATE

MSP PAYEE NUMBER

NOTE: AN APPLICATION FORM IS REQUIRED FOR EVERY PAYEE NUMBER