College of
HEALTH AND CARE
PROFESSIONALS OF BC

OPTOMETRY

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

Place of practice _____
Name

_____
Address

_____ _____ _____
City Province Postal code

Registrant _____
Name

_____
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 that apply.

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

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 _____.
day/month/year

_____ _____
Signature day/month/year

b) **Low vision services** and that I have access to and will employ low vision instrumentation which is appropriate when billing for low vision services, effective _____.
day/month/year

_____ _____
Signature day/month/year

Please note: *A separate form must be completed for each place of practice. Return completed form(s) to registration@chcpbc.org.*