Provider Registration Form

Provider Information:

Last Name:_____ First Name:_____
Unique ID # (For dental) _____ Specialty:_____

Clinic/Office Information:

Clinic Name:_____
Address: _____ Unit/Suite:_____
City: _____ Province: _____
Postal Code:_____ Clinic ID# (If applicable)_____

Contact:

Telephone:_____ Fax:_____
Email Address: _____ Website:_____
Facebook/Twitter _____

Additional Offices:

Clinic Name	Clinic Id# (If applicable)	Complete Address	Telephone

Associates:

Unique ID # (For dental)	Name	Clinic Id # (If applicable)	Clinic Name	Signature

By completing and signing this Provider Registration Form you will become a Provider under the First Canadian Benefits (FCB) Health Network (as defined herein the "Provider").

Upon the submission of a claim as a Provider, you will be subject to the Suggested Program Guidelines of the FCB Health Network. This document can be found on the FCB website at www.fcbhealthnetwork.ca by clicking 'Enroll Now'.

As signatory to this Registration Form, you will be responsible for all services billed and paid by the eligible member's plan regardless of the corporate structure of the clinic from which you operate.

Providers attest to their enrollment and good standing with their respective Provincial/Territorial Licensing Body.

The term of this registration shall commence on the date the Provider receives a Provider Registration Number from FCB.

Name:_____ **Date:**_____

Signature:_____

Fill out particulars and fax to FCB at (416) 929-6876

FCB
421 Bloor Street East, # 206, Toronto, Ontario. M4W 3T1
Tel: (416) 929-4685, 1-888-929-4685 Fax: 416-929-6876
Email: info@fcbhealthnetwork.ca Website: fcbhealthnetwork.ca