

# CALL BACK VERIFICATION AND INVOICE

## PART A - VERIFICATION OF CALLBACK

Person Initiating Callback: \_\_\_\_\_

Title of Person Initiating Callback: \_\_\_\_\_

Date/Time Callback Initiated	Name of Physician called back	Physician was designated for this Callback?	Name of patient	Symptoms indicating emergency care was required
		[ <input type="checkbox"/> ] YES [ <input type="checkbox"/> ] NO		

With respect to the above noted call back:

1. I assessed the patient as requiring medical services on an emergency basis; and
2. Reasonable steps were taken to determine that the emergency medical services required by the patient could not have been provided (due to issues of competence or availability) by a physician who had on-going responsibility for the care of the patient (either directly or by virtue of his or her call group); by a physician who was on-call or by a physician who was being paid to be on site, on shift or otherwise available.

I certify all the information on this form to be correct.

\_\_\_\_\_  
Signature of Person Initiating Callback

\_\_\_\_\_  
Date

## PART B - CALLBACK CLAIM

Name of Physician: \_\_\_\_\_

Are you designated by VIHA for Callback payments? [  ] YES [  ] NO

MSP Number: \_\_\_\_\_

If yes, indicate name of designated Callback Group: \_\_\_\_\_

If no, indicate in the last column below that payment is sought on an Exception Basis

Date/time Callback Received	Name of Person Initiating Callback	Date/Time Physician Physically Attended the Patient	Name of patient	Patient PHN Number	Facility Where Patient Seen	Physician provided Surgical Assistant services in relation to the Callback	Are You Seeking Approval on Exception Basis?
						[ <input type="checkbox"/> ] YES [ <input type="checkbox"/> ] NO	[ <input type="checkbox"/> ] YES [ <input type="checkbox"/> ] NO

With respect to the above noted call back:

1. The patient was not my patient or the patient of a colleague for whose patients I had accepted responsibility; and
2. At the time of the call back I was not on site at the facility noted above, or scheduled to be on site, or scheduled to be next on site at a time when the patients needs could be adequately met; nor was I on call or being paid to be on site, on shift, or otherwise available.
3. I confirm that I am not receiving isolation allowance fund payments and was not receiving such payments at the time of the call back noted above.
4. I confirm that I am credentialed and privileged to provide services at the facility named above.
5. I authorize the Ministry of Health Services to release to the Health Authority named above any information related to the claim reflected on this invoice, excluding patient personal information (i.e. the name and personal health number of the patient), that, in the reasonable opinion of the ministry, is relevant to assessing this claim and if necessary, resolving any dispute over this claim through arbitration or otherwise. Such information will include but not be limited to compensation/billing information (excluding patient personal information).

I certify all the information on this form to be correct.

\_\_\_\_\_  
Signature of Physician Claiming Callback

\_\_\_\_\_  
Date

1. Both Part A and Part B must be completely filled out prior to submitting to VIHA Physician Compensation for processing.
2. Completed Callback claims must be received within 30 days of the Callback service to be eligible for payment.
3. Mail completed claims to Vancouver Island Health Authority attn: Physician Compensation, 1200 Dufferin Cres. Nanaimo BC, V9S 2B7
4. Callback Invoice and Verification forms received after 30 days from time of the Callback will be returned to the physician submitting the claim and not paid.