SMA SASKATCHEWAN MEDICAL ASSOCIATION

Saskatchewan

ENTITLEMENT REQUEST

SPECIALIZED ASSESSMENT AND WRITTEN REPORT INVOLVING A NURSE PRACTITIONER REFERRAL (14B)

Applicant Information

Physician Name: ______________________ Phone Number: ______________________

Email Address: ______________________ MSB Billing Number: ______________________

Mode: ____________

(List all applicable modes 1: Fee-for-service, 9: Non-fee-for-service (alternative payment), 0: Primary Care Health Clinic)

Location(s) where services are being/will be provided: ______________________

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Authorization for Release of Information

☐ I authorize the SMA to share information provided as part of this application with other stakeholders (i.e., Ministry of Health, CPSS, etc.) for the purpose of determining eligibility under the entitlement process.

☐ I authorize the SMA to share my name on a publicly available list of physicians offering specialized assessment services in one or more of the areas identified by me below.

Declaration

1. Are you currently registered for payment under the Transitional Payment Model (TPM)?

☐ Yes ☐ No

2. Are you currently providing/intending to provide specialized assessment services in these areas? Please list all.

Currently Providing	Intending to Provide		Currently Providing	Intending to Provide	
☐	☐	Anesthesia	☐	☐	Addictions Medicine
☐	☐	Obstetrics	☐	☐	Dermatology
☐	☐	General Surgery	☐	☐	Palliative Care
☐	☐	Allergy	☐	☐	Designated Pain Clinic
☐	☐	Sports Medicine	☐	☐	Child Psychiatric Care

3. Are your relevant additional post-graduate training/qualifications listed on your CPSS public profile?

☐ Yes ☐ No

4. If no, please list your relevant additional post-graduate training/qualifications in the above areas and provide copies with your application (attach additional pages as needed): ______________________

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Process

1. Send your completed application and copies of your relevant additional post-graduate training/qualifications to the SMA Tariff Committee at tariff@sma.sk.ca
2. The SMA Tariff Committee and the Medical Services Branch of the Ministry of Health will jointly review your application and will contact you at your above-mentioned email address with any requests for additional information, and with the decision of your application. If approved, eligible services can be billed under 14B effective from the approval date outlined in the letter you will receive.

Signature: ______________________ **Date:** ______________________