ALBERTA BLUE CROSS®

APPLICATION FOR AN ALBERTA BLUE CROSS AGREEMENT (ALBERTA)

TO BE USED SOLELY FOR PHARMACIES LOCATED IN ALBERTA

Reason for request	Pharmacy operations effective date (YYYY-MM-DD)
☐ New pharmacy ☐ Change of ownership (existing provider number)_____ ☐ Other (please specify) _____	

1. PHARMACY LICENCE INFORMATION

Pharmacy operating licence number (as assigned by the Alberta College of Pharmacists)

Identify the categories of licence that apply to this pharmacy

☐ Community/retail ☐ Compounding/repackaging ☐ Mail order ☐ Satellite

If the category is satellite, provide the name and licence number of the community pharmacy it operates under.

Name of licensee pharmacist	Registration number of licensee pharmacist (as assigned by the Alberta College of Pharmacists)

2. PHARMACY BUSINESS INFORMATION

Legal name			Provincial corporate registration number
Operating name (if different)			Pharmacy email address
Pharmacy site address	City	Province	Postal code
Pharmacy mailing address (if different than site)	City	Province	Postal code
Pharmacy mailing address for **reconciliation/payment summaries**	City	Province	Postal code

Pharmacy phone number	Pharmacy fax number	Current software vendor

3. PHARMACY CLASSIFICATION

☐ **Independent**	☐ **Franchise** Franchise name: _____
☐ **Banner** Banner name: _____	☐ **Chain** Chain name: _____

4. BANKING INFORMATION

Branch (transit) number (maximum 5 digits)	Bank number (maximum 3 digits)	Account number (maximum 12 digits)

NOTE: In order for this authorization to be processed, a copy of a pre-printed void cheque identifying the pharmacy must be attached. If you do not have a pre-printed cheque, attach a signed letter from your bank identifying the pharmacy and the account details.

For Alberta Blue Cross use only	Date effective (YYYY-MM-DD)	Date processed (YYYY-MM-DD)

5. PHARMACY OWNERSHIP INFORMATION

What is the legal form of ownership? ☐ Corporation/Ltd./Inc. ☐ Partnership/Firm ☐ Sole proprietorship

If the legal form of ownership is corporation/Ltd./Inc., complete this section:

List all the names and home addresses of the following individuals. If additional writing space is required, please attach a separate piece of paper.

Directors

Name	Address	City	Province	Postal code

Authorized signing officers

Name	Address	City	Province	Postal code

Legal and beneficial holders/owners of the **voting** shares. Indicate the percentage of the **voting** shares each shareholder owns.
In addition, if one or more are corporations or other entities, list the names of **all** of the beneficial owners of each.

Name	Address	City	Province	Postal code	% shares

If the legal form of ownership is a partnership/firm, complete this section:
List the names and home addresses of the partners. Indicate the percentage of the partnership that each partner legally/beneficially owns.

Name	Address	City	Province	Postal code	%

If the legal form of ownership is a sole proprietorship, complete this section:
List the name and home address of the individual who is the proprietor.

Name	Address	City	Province	Postal code

6. PHARMACY AFFILIATIONS

1. Does the pharmacy have a contract or other business relationship to provide pharmaceutical services to a continuing care/supportive living facility or facilities*?

☐ Yes ☐ No If yes, please complete the following:

Name

Category

☐ Group home
☐ Assisted living
☐ Lodge
☐ Other: _____

Will the pharmacy be submitting claims to Alberta Blue Cross for residents of the facility? ☐ **Yes** ☐ **No**
If yes, please provide a copy of the contract or other written agreement with the facility.

**Please use a separate piece of paper to provide the same information for any additional facilities.*

2. Is the pharmacy part of a hospital facility?

☐ Yes ☐ No If yes, please complete the following:

Name

The pharmacy operates as an ☐ In-patient pharmacy ☐ Out-patient pharmacy

3. Do any of the owners/directors/officers have an affiliation with or own interest in the following:

Another pharmacy ☐ Yes ☐ No Name of pharmacy: _____

A physician's office ☐ Yes ☐ No Name of physician's office: _____

Continuing care/supportive living facility ☐ Yes ☐ No Name of facility: _____

4. Is the pharmacy part of a buying group?:

☐ Yes ☐ No If yes, please provide the name of the buying group: _____

7. CERTIFICATION AND AUTHORIZATION

I certify that I am an owner or individual legally authorized to sign on behalf of the legal entity. I further certify that the information provided on this application is both true and complete, and understand that Alberta Blue Cross is relying upon the truthfulness and accuracy of the information when making its decision to enter into a Provider Agreement. I also authorize Alberta Blue Cross to directly deposit payments for claims into the bank account identified herein.

Authorized signature	Name (please print)	Title
Confidential email	Daytime phone number	Date (YYYY-MM-DD)

PLEASE RETURN THIS FULLY COMPLETED FORM		FOR ASSISTANCE
By fax 780-498-3549	**By email** pamt@ab.bluecross.ca	**By phone** **1-844-498-8292**

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