

The pharmacy will be changing the following information (please check all that apply and specify the effective date of change(s)):			
<input type="checkbox"/> Operating name Date of change (YYYY/MM/DD)	<input type="checkbox"/> Site address (relocation) Date of change (YYYY/MM/DD)	<input type="checkbox"/> Mailing address Date of change (YYYY/MM/DD)	<input type="checkbox"/> Phone/Fax number Date of change (YYYY/MM/DD)

1. PHARMACY BUSINESS INFORMATION BEFORE THE CHANGE(S)			
Legal name		Alberta Blue Cross provider number	
Operating name (if different)			
Pharmacy site address	City	Province	Postal code
Pharmacy mailing address (if different than site)	City	Province	Postal code
Pharmacy phone number	Pharmacy fax number	Email address	

2. APPLICABLE CHANGE(S)				
<input type="checkbox"/> Operating name (to be completed only if changing)	New operating name			
<input type="checkbox"/> Site address (to be completed only if changing)	New site address	City	Province	Postal code
<input type="checkbox"/> Mailing address (to be completed only if changing)	New mailing address	City	Province	Postal code
<input type="checkbox"/> Phone/fax number (to be completed only if changing)	New phone number	New fax number		

3. CERTIFICATION		
<i>I certify that I am an owner or individual legally authorized to sign on behalf of the legal entity. I understand that, where applicable, the information provided on this form replaces information previously provided to Alberta Blue Cross.</i>		
Authorized Signature	Name (please print)	Title
Date (YYYY/MM/DD)	Daytime phone number	

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

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