Important registration information

Thank you for your interest in registering for direct billing services.

Please complete the application for an Alberta Blue Cross Agreement, **then print and sign it**. The form can then be

- **faxed to 780-498-3549;** or
- scanned and emailed to **pamt@ab.bluecross.ca**.

Please note that it is not necessary to mail the original copy to our office.

Providing this information is the first step in applying for an Agreement. Alberta Blue Cross will review the information and, if approved, send you the hard copy Agreement via courier.

When returning the form, please indicate the address where you would like the Agreement couriered to. We cannot courier to post office boxes.

If you have any questions or concerns, please contact us by email as noted above or call our toll-free number 1-844-498-8292.

ALBERTA BLUE CROSS®

APPLICATION FOR AN ALBERTA BLUE CROSS AGREEMENT (WESTERN)

TO BE USED SOLELY FOR PHARMACIES LOCATED IN BC, SK, AND THE TERRITORIES

Reason for request	Pharmacy operations (choose all that apply)	Pharmacy operating effective date (YYYY/MM/DD)
☐ New pharmacy ☐ Change of ownership (existing provider number) ____ ☐ Other (please specify) ____	☐ Community ☐ Long-term care ☐ Internet ☐ Mail order ☐ Hospital ☐ Compounding ☐ Other (please specify) ____	____

1. PHARMACY BUSINESS INFORMATION

Legal name			
Operating name (if different)			
Pharmacy site address	City	Province	Postal code
Pharmacy mailing address (if different than site)	City	Province	Postal code
Mailing address for **reconciliation/payment summaries**	City	Province	Postal code

Pharmacy phone number	Pharmacy fax number	Confidential email address
Name of managing pharmacist		Current software vendor

2. PHARMACY CLASSIFICATION

☐ Independent

☐ Franchise ------------------------Franchise name: ____

☐ Banner ---------------------------- Banner name: ____

☐ Chain ---------------------------- Chain name: ____

3. 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.

4. 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
Date (YYYY/MM/DD)	Daytime phone number	

PLEASE RETURN THIS FULLY COMPLETED FORM — FOR ASSISTANCE

By fax	By email	By phone
780-498-3549	pamt@ab.bluecross.ca	**1-844-498-8292**

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

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