

**TO BE USED SOLELY FOR PHARMACIES LOCATED IN MB, ON, PE, NB, NS & NL**

Reason for request <input type="checkbox"/> New pharmacy <input type="checkbox"/> Change of ownership (existing provider number) _____ <input type="checkbox"/> Other (please specify) _____	Pharmacy operations (choose all that apply) <input type="checkbox"/> Community <input type="checkbox"/> Long-term care <input type="checkbox"/> Internet <input type="checkbox"/> Mail order <input type="checkbox"/> Hospital <input type="checkbox"/> Compounding <input type="checkbox"/> Other (please specify) _____	Pharmacy operating effective date (YYYY/MM/DD) _____
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**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 <b>reconciliation/payment summaries</b>	City	Province	Postal code
Pharmacy phone number	Pharmacy fax number	Confidential email address	
Name of managing pharmacist		Current software vendor	

**2. PHARMACY CLASSIFICATION**

<input type="checkbox"/> Independent	<input type="checkbox"/> Franchise ----- Franchise name: _____
<input type="checkbox"/> Banner ----- Banner name: _____	<input type="checkbox"/> 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 form is both true and complete, and agree that all claims must be submitted in compliance with the Alberta Blue Cross Guidelines for Access to PRIDE RT. 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**

<b>By fax</b> 780-498-3549	<b>By email</b> pamt@ab.bluecross.ca	<b>By phone</b> <b>1-844-498-8292</b>
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For Alberta Blue Cross use only	Date effective (YYYY/MM/DD)	Date processed (YYYY/MM/DD)

