New Brunswick Drug Plans / Régimes de médicaments du Nouveau Brunswick

Participating Provider Agreement
New Brunswick Drug Plans

Please fax your completed Participating Provider Agreement to 506-869-9673.

Pharmacy Information *(Required)*

Pharmacy Name: _____

Owner/Operator: _____

Building Number and Street: _____

City/Town: _____ Province: _____ Postal Code: |_|_|_| |_|_|_|

Telephone Number: _____ Fax Number: _____

Accreditation Number: _____ Software Vendor: _____

E-mail Address: _____

Provider Agreement *(Required)*

I acknowledge that I have read and understand the requirements of the New Brunswick Prescription Drug Program and the New Brunswick Drug Plan (referred to as the NB Drug Plans), including the *Prescription Drug Payment Act and Regulation* and the *Prescription and Catastrophic Drug Insurance Act and Regulation* as well as the requirements of other government sponsored plans. I acknowledge that I have read and understand the policies of the NB Drug Plans and other government sponsored plans and agree to all obligations relating to participating providers.
I understand that all claims submitted under the NB Drug Plans and other government sponsored plans are subject to audit and recoveries, as outlined in the New Brunswick Drug Plans Provider Audit Guide and other directives issued by the Government of New Brunswick or the administrator, Medavie Blue Cross, as amended from time to time. It is understood that overpayments may be deducted from amounts payable.

I acknowledge that any collection, use and disclosure of Personal Health Information for the NB Drug Plans or other government sponsored plans will be in accordance with the *Personal Health Information Privacy and Access Act*.

Name: _____

Signature: _____ Date: _____

If you have any questions, please call 1-800-332-3691.

Administered by Medavie Blue Cross on behalf of the Government of New Brunswick

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