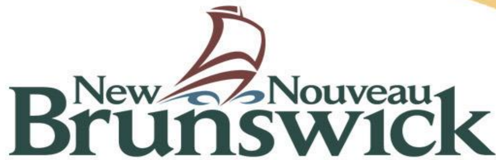


Request for Medicare Account Number(s) - Single Service Provider

To apply for an additional account number with the Department of Health - Medicare Payments:

1. You must be registered as a service provider with New Brunswick Medicare
2. You must need an additional account (i.e. on-call, Shadow-billing or group)
3. You must complete and submit the application "**Medicare Account Request Form**"

Instructions

Please review the ***Account Policy*** (Medicare Policy Manual, Section 6, Policy 2) found here: http://intra.gnb.ca/dhw-msme/medicare/policies-e.asp.

Should you still have any questions about the type of account(s) you require, please contact us by phone or email.

Complete all relevant sections of the form.

Please include supporting documents as required with your application to ensure accurate and timely registration. Please attach a void cheque or bank authorization form to allow for Direct Deposit transfers (if applying for multiple account, please ensure it is clearly indicated which bank information is to be used for each account if they are different.)

Supporting Documentation:

- Void cheque
- Bank authorization

Please note that the **original** completed form(s) must be returned to:

Department of Health
Medicare Payments
PO Box 5100
Fredericton, NB E3B 5G8

Should you have any questions or concerns regarding the completion of this form, please contact Medicare Payments by phone at (506) 453-8274 or email at DHMedPay@gnb.ca

Medicare Account Request Form

Please indicate the type of account(s) being requested:

- [ ] On-call account (**Salaried Physician Only**)
- [ ] Shadow-billing account (**Salaried Physician Only**)
- [ ] Sessional Shadow-billing account
  Please indicate type of sessional arrangement: ______________________
- [ ] Alternate Funding Plan (AFP) Shadow-billing account
  Please indicate type of AFP arrangement: ______________________
- [ ] Alternate Payment Plan (APP) Shadow-billing account
  Please indicate type of APP arrangement: ______________________
- [ ] Other, please specify
  Name of additional account: ______________________

Section 1 - Account Information

Effective Date of Account(s): ______________________ (DD/MM/YYYY)

Note: You will not be able to bill for services performed prior to this date

Mailing Address:

____

____

____

____

Contact Number: ______________________

*Private line if available - for use by Medicare personnel only

Email Address: ______________________

Section 2 - Service Provider Information

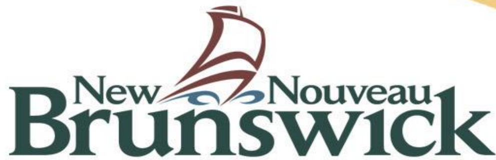
First Name: ______________________

Last Name: ______________________

Service Provider #: ______________ (commonly referred to as Personal Billing number)

Section 3 - Delegate Information

A delegate is a person other than the physician (for example a secretary or administrative assistant) who is given the authority by a physician to complete certain tasks or view certain information on the physician's behalf.



The following is a list of responsibilities that may be given to a delegate:

1 - Transmit/submit claims,

2 - Authorize adjustments and/or recoveries to said account(s), to ensure billings are accurate and appropriate,

3 - Communicate with Medicare regarding information associated with said account(s),

4 - Request changes to said account(s) such as address changes and banking information updates,

5 - View biweekly reconciliation statements pertaining to said account(s) in ECP (Electronic Communication to Physicians).

6- View your *Service Provider Profile by Individual Service Code*

The person(s) listed below is authorized to act as delegate for matters related to the above-mentioned account(s).

Please ensure to clearly circle the "**delegated responsibilities**" number. The number refers to the list of responsibilities listed above.

Delegate #1

Name: ______________________ Delegated Responsibilities (Please circle) 1 2 3 4 5 6

Email Address: ______________________ Delegate's Signature: ________________

Delegate #2

Name: ______________________ Delegated Responsibilities (Please circle) 1 2 3 4 5 6

Email Address: ______________________ Delegate's Signature: ________________

Section 4 - Agreement

I hereby agree to the following:

1 - I am responsible to ensure that all claim submissions are made to the appropriate account;

2 - I authorize Medicare to make adjustments and recoveries from the account to ensure claims are accurately submitted on my behalf;

3 - I understand that Medicare may make deductions from my earnings with respect to a third party request as authorized by law;

4 - As per section 3 above, I hereby give authority to my delegate to act on my behalf for the account(s) noted above; and

5 - I understand that I continue to be fully responsible for the billings and related Medicare documents.

Physician Signature: ______________________ Date: ________________