Request for Medicare Account Number(s) - Multiple Service Providers

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**"
4. The account willhave a membership of 2 or more physicians

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.

By indicating a lead physician in **section 1**; future changes to the account such as delegate changes, can be made with only his/her signature. Should you not select a lead physician; Medicare Payments will require approval from all members prior to completing a change request. In **section 2**, the Service provider number is required. In **section 3**, the group may appoint two delegates to act on the group's behalf. Only physicians appointed as a delegate will be provided access to the biweekly reconciliation statements.

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 - Multiple Service Providers

Please indicate the type of account being requested and account name:

- ☐ 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

Account Name: _____

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: _____

_____ Email Address: _____

Lead Physician: _____

Note: The lead physician will have the ability to make changes to the account on behalf of the membership and may be forwarded general correspondance from Medicare.

Section 2 - Service Provider Information

Please list all Service Providers that will be members of this account (including lead physician):

First Name	Last Name	Service Provider #

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 responsbilities 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).

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

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

Delegate #1

Name: _____ Delegated Responsibilites (Please circle) 1 2 3 4 5

Email Address: _____ Delegate's Signature: _____

Delegate #2

Name: _____ Delegated Responsibilites (Please circle) 1 2 3 4 5

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.

Lead Phsycian's Signature _____ Date: _____

Member's Signature	Service Provider #	Date