

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 will have 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.

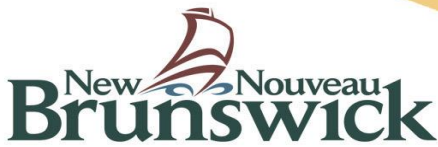
Supporting Documentation:

- 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 correspondence 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 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).

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

Email Address: _____ Delegate's Signature: _____

Delegate #2

Name: _____ Delegated Responsibilities
(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 Physician's Signature _____

Date: _____

Member's Signature	Service Provider #	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____