Veterans Affairs Canada | Anciens Combattants Canada

National Defence | Défense nationale

Royal Canadian Mounted Police | Gendarmerie royale du Canada

Provider Registration and Claims Submission Agreement

Protected "B" when completed

Provider Information

Provider Name: _____

Business Name: _____

Business Address: _____

City: _____ Province/Territory: _____ Postal Code: _____

Will any services be provided outside this address? ❑ Yes ❑ No ❑ If yes, provide address: _____

_____

Telephone Number: _____ Fax Number: _____

E-mail Address: _____ Language of Correspondence: ❑ English ❑ French

Contact Person (if different from above): _____

Business Information

Type of Business: ❑ Sole Proprietorship ❑ Partnership ❑ Corporation (incl. professional)

Name(s) of Owner(s) : _____ Telephone: _____

Business Record Location Address: _____

City: _____ Province/Territory: _____ Postal Code: _____

Is business accredited: ❑ Yes ❑ No If yes, by what organization? _____

Provider Type/Specialty

Provider Type (e.g. Physician, Dentist, Hospital)/Specialty: _____

Medavie Blue Cross Provider Number (if applicable): _____

Regulatory Body Name (or association, if unregulated): _____

License/Registration Number: _____ Expiry Date: _____ Province/Territory of Registration: _____

Payment Information - Electronic Funds Transfer (EFT)

I/We instruct Medavie Blue Cross to set up direct EFT payments. This form authorizes deposits to the account and does not authorize withdrawals or any other transactions with respect to the account. All information will be treated as private and confidential. I/We will advise Medavie Blue Cross promptly of any changes to bank, branch or account number.

Complete bank information below. If submitting via mail or fax, attach copy of VOID cheque.

Bank Name: _____ Branch Name: _____

Branch Address: _____

City: _____ Province/Territory: _____ Postal Code: _____

Bank No: ⌊_⌊_⌊ Branch/Transit No.: ⌊_⌊_⌊_⌊_⌊ Account No.: _____

Effective Date: _____ Authorized Signature(s): _____

OR

Cheque Payment Name: _____

Mail/Cheque Address (if different from above): _____

Address: _____

City: _____ Province/Territory: _____ Postal Code: _____

Consent

All information submitted in this form, including any attachments, is true, current and complete to the best of my knowledge.

Date: _____ Authorized Signature(s): _____ Name: _____

You will be registered for all Departments whose criteria you have met.

Submit Completed Form to:

Medavie Blue Cross
Corporate Provider Services
644 Main St. PO Box 220, Moncton, NB E1C 8L3

E-mail: provider@medavie.bluecross.ca
Telephone: 1-888-261-4033
Fax: 506-869-9673

MEDAVIE BLUE CROSS™

Canada

FHCPB-001E 06/17

Provider Claims Submission Agreement

By registering as a provider and submitting claims to Medavie Inc., operating under the business name Medavie Blue Cross ("Medavie"), You ("You"or "Your") agree to the following terms and conditions ("Terms a nd Conditions ") . These Terms and Conditions include:

- The Provider Information Kit;
- The Health Benefits Programs; and,
- The End User Agreement: governing Your use of the Health Professional secure section of Medavie's website.

These Terms and Conditions, together with all applicable agreements and documents referenced in these Terms and Conditions, form Medavie's agreement with You. You are responsible for ensuring that Your employees, agents and subcontractors comply with these Terms and Conditions. Medavie may change this agreement, including the applicable agreements and documents referenced hereto with or without Your consent. Medavie will notify You of any change to these Terms and Conditions upon Your access or use of the Health Professional secure section of Medavie's website. If you continue to submit claims after any such change is effective, You will be deemed to have accepted the change.

1. Definitions. In this agreement:
   (1) VAC means Veterans Affairs Canada.
   (2) CAF means the Canadian Armed Forces.
   (3) RCMP means the Royal Canadian Mounted Police.
   (4) DND means Department of National Defence
   (5) IRCC means Immigration, Refugees and Citizenship Canada.
   (6) Departments means VAC, DND, RCMP and IRCC.
   (7) IFHP means Interim Federal Health Program
   (8) Provider Information Kit means the document bearing this title, as amended, provided or made available to all providers by Medavie and which sets out additional terms and conditions, policies and procedures required for the submission of claims.
   (9) Health Benefits Programs means the benefit plan or program established by the Departments under which Your client is covered.
   (10) Business Day means a day other than a Saturday, Sunday, or statutory holiday in the Province of New Brunswick.
2. Licenses, Permits. In order to be registered as a provider with Medavie, You must obtain and retain an unrestricted license and be eligible to practice professional services under the accepted guidelines of Your provincial/territorial licensing body as recognized by Medavie and the Departments, or, where regulation does not exist, of Your provincial/territorial healthcare association as recognized by Medavie and the Departments. You are responsible to immediately notify Medavie of any restriction, conditions or limitations to practice, or loss of Your licensure.
3. Health Benefits Programs. The Departments establish the policy guidelines and rules with respect to eligibility to the Health Benefits Program and any benefits covered thereunder. Medavie will notify You of any change to these policy guidelines and rules upon Your access or use of the Health Professional secure section of Medavie's website.
4. Submission of Claims. You acknowledge that the claims that you submit, whether electronically or on paper, to Medavie for payment of healthcare services provided to Your clients under VAC, CAF, RCMP, IFHP and Medavie Blue Cross and subsidiary Blue Cross plans of Canada Health Benefits Programs are subject to those terms and conditions. By submitting claims to Medavie, you represent and warrant to Medavie that the claims are authentic and constitute an accurate account of the services that you provided and the charges billed thereon are in accordance with these Terms and Conditions.
5. Prior IFHP Verification. Providers must verify the eligibility status of each IFHP client **before** services are rendered.
6. IFHP Providers. Providers registering to become an IFHP approved provider are required to read and accept these Terms and Conditions to be an eligible approved provider. Providers registering on-line to become an IFHP approved provider will be prompted to read and accept these Terms and Conditions at the time of registration. Providers registering by mail, telephone, fax or submission of first claim or prior approval, will receive a printed copy of these Terms and Conditions upon approval. The signed acceptance of the Terms and Conditions (for each location, if applicable), MUST be returned to Medavie Blue Cross within sixty (60) days of becoming an IFHP approved provider. Failure to do so will result in termination of IFHP approved provider status.
7. Collection and Use of Personal Information. All personal information collected from Your client is confidential and will not be used or disclosed other than for the purposes of administering the Health Benefits Programs, without Your client's consent, unless in accordance with the applicable privacy legislation. You agree to observe and comply with the requirements of all applicable privacy legislation and amendments thereto with respect to any such personal information in Your possession.
8. Audit Rights. Medavie will have the right to audit all data and documentation, including the right to conduct on-site audits, relating to claims for the purposes of administering the Health Benefits Programs.
9. Consent to Use and Disclose Contact Information. You authorize Medavie and the Departments to publish Your contact information for the purposes of communicating provider services to clients, unless You advise Medavie otherwise in writing. You further authorize Medavie to disclose Your contact information to third parties for the purpose of conducting surveys measuring provider satisfaction with Medavie services.
10. Indemnity. You shall save harmless and fully indemnify Medavie, its successors, assigns, directors, officers, employees and agents from and against all claims, demands, actions, losses, damages, liability, judgements, costs and expenses which they may suffer or incur as a result of, in respect of, or arising out of any error, omission, breach of the agreement on Your part, Your employees' part or Your subcontractors' part, or any negligence or other tortious act committed by You, Your employees or Your subcontractors.
11. Termination. This agreement is effective until terminated by You or Medavie. You may terminate this agreement at any time by giving written notice to Medavie. Medavie may terminate this agreement at any time and for any reason with or without notice to You.
12. Fees: You shall not submit a claim with a fee/rate exceeding the fee/rate charged by you to any patient paying cash for the same service/product. You will be required to substantiate cash rates upon audit.
13. General.

    13.1 Benefit and Binding. This agreement shall ensure to the benefit of and be binding upon the respective heirs, executors, administrators, successors, and permitted assigns of the parties hereto, as applicable.
    13.2 Assignment. This agreement is not assignable by You, in whole or in part, without the specific written consent of Medavie. Medavie may assign this agreement at any time without notice or Your consent.
    13.3 Severability. If any provision of this agreement is determined to be invalid or unenforceable, in whole or in part, such invalidity or unenforceability shall attach only to such provision, and all other provisions hereof shall continue in full force and effect.
    13.4 Applicable Laws. This agreement will be governed by the laws applicable in the Province of New Brunswick. You irrevocably submit to the jurisdiction of the courts in the Province of New Brunswick. The parties hereby waive any right to a jury trial.
    13.5 Survival. The following provisions will survive the termination of this agreement: Section 8 (Audit Rights), Section 7 (Collection and Use of Personal Information), Section 13 (General).
    13.6 Effective Date. This agreement will become effective when You sign below or agree to it electronically.

Date: _____ **Provider or Authorized Signature:** _____

Provider or Authorized Person's Printed Name: _____ **Title:** _____

Medavie Blue Cross Provider Number (if applicable): _____