

Change to existing set up	
Details of change requested (example: address, phone number and email)	Effective date (YYYY/MM/DD)

Provider information				
Legal name of the individual provider or clinic		Operating or practice name—if different than legal name		
Business address				
City	Province	Postal code	Phone number	Fax number

Contact information (person to be contacted regarding online claim submission and restricted information)				
Last name		First name		Initial
Phone number	Fax number	Email address (for confidential information pertaining to login credentials.)		

Note: all fields on this form must be completed. Your request for change cannot be processed without all the information requested.

Authorization	
<p>I, _____ (please print), as an authorized representative of the above-mentioned health services provider, hereby authorize Alberta Blue Cross to enable this practice or place of business to participate in online claim submission and processing for health services rendered, according to the terms of the Alberta Blue Cross Health Services Provider Web Site Policy and Online Billing Agreement.</p>	
Signature _____	Date _____

Please mail or fax your completed form to
Alberta Blue Cross
Health Services Provider Relations
10009 108 Street NW
Edmonton, AB T5J 3C5
Fax: 780-498-3544

For assistance with this form or more information about online health services claims submission, please call
780-498-8083 (Edmonton and area)
1-800-588-1195 (toll free)

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