

The pharmacy will be changing the following information (please check all that apply and specify the effective date of changes):

<input type="checkbox"/> Operating name Date of change (YYYY-MM-DD)	<input type="checkbox"/> Phone/fax number Date of change (YYYY-MM-DD)	<input type="checkbox"/> Mailing address Date of change (YYYY-MM/DD)	<input type="checkbox"/> Site address (relocation) Date of change (YYYY-MM-DD)
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1. PHARMACY BUSINESS INFORMATION BEFORE THE CHANGES

Legal name		Alberta Blue Cross provider number	
Operating name			
Pharmacy site address	City	Province	Postal code
Pharmacy mailing address (if different than site)	City	Province	Postal code
Pharmacy phone number	Pharmacy fax number	Pharmacy email address	

2. APPLICABLE CHANGES

<input type="checkbox"/> Operating name (to be completed only if changing)	New operating name			
<input type="checkbox"/> Site address (to be completed only if changing)	New site address	City	Province	Postal code
<input type="checkbox"/> Mailing address (to be completed only if changing)	New mailing address	City	Province	Postal code
<input type="checkbox"/> Phone/fax number (to be completed only if changing)	New phone number	New fax number		

3. CERTIFICATION

I certify that I am an owner or individual legally authorized to sign on behalf of the legal entity. I understand that, where applicable, the information provided on this form replaces information previously provided to Alberta Blue Cross.

Authorized signature	Name (please print)	Title
Confidential email	Daytime phone number	Date (YYYY-MM-DD)

PLEASE RETURN THIS FULLY COMPLETED FORM FOR ASSISTANCE

By fax 780-498-3549	By email pamt@ab.bluecross.ca	By phone 1-844-498-8292
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For Alberta Blue Cross use only	Date processed (YYYY-MM-DD)
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