Medicare Add or Remove a Service Provider to an Existing Account

Guidelines

The purpose of this form is to add (or remove) a physician to an existing Medicare group account to allow for claim submission and payment.

Please complete this form **PRINT**, **SIGN** and return the form using one of the following:

Department of Health
Medicare Payments
PO Box 5100
Fredericton, NB E3B 5G8

NEW **Forms can be emailed to:**
dhmedpay@gnb.ca

If you have any questions or concerns about this form, please contact Medicare Payments at (506) 453-8274, option 1 or by email at DHMEDPAY@gnb.ca.

Important: Throughout this form, fields marked with an **asterisk** (*) are required fields. These fields are important to ensure prompt and appropriate action. **Please ensure all required fields are complete in order to avoid any delays.**

Section 1 – Service Provider Information

*Last Name: *First Name:

*Service Provider Number:

*Contact Number: *Email:

Private line if available – for use by Medicare personnel only.

Section 2 – Account Information

Add or **remove** the service provider listed above from the following group account:

*Account Name:	
*Account Number:	

☐ **Add** Start date (dd/mm/yy): _____

☐ **Remove** End date (dd/mm/yy): _____

Services performed cannot be billed prior to this date.

Section 3 – Delegate Information

By completing this section, you are authorizing the delegate named below to:

- ✓ Submit/transmit claims on this account(s);
- ✓ Communicate with NB Medicare regarding submitted claims;
- ✓ Authorize adjustments and/or recoveries to ensure claims are accurately submitted on the physician's behalf for the said account(s).

*****Delegate's Name:

*****Contact Number:

*****Email: Username (if applicable):

Note: A separate "*Medicare Delegate Authorization Form*" or "*RHA Delegate Authorization Form*" must be completed if a service provider wishes to appoint more than one delegate.

Section 4 – Agreement

I hereby agree to the following:

1. I am personally responsible to ensure that all billings are made under the appropriate account.
2. I authorize Medicare to make adjustments and recoveries from the account in relation to claims submitted on my behalf but not in excess of the overall payments made to the account in my name.
3. I authorize Medicare to make deductions from my earnings under this account number with respect to a third party request as authorized by law.
4. I authorize the delegate to act on my behalf for the account noted in section 3.
5. I understand that I continue to be fully responsible for the billings and related Medicare documents.

*****Service Provider's signature: *****Date:

If this form is being completed by someone other than the service provider, or delegate named in section 3, please provide the following information:

Name of Person completing this form:

Contact Number:

Email: