PHARMACY STAKEHOLDER REGISTRATION FORM

CANADIAN BENEFIT PROVIDERS

PHARMACY INFORMATION Please print clearly.

OPERATING NAME			
IS THIS PHARMACY PART OF A CHAIN?	(Y/N)	IF YES, INDICATE CORPORATE NAME / CHAIN STORE #	EFFECTIVE DATE OF OPENING
TAKING OVER FOR AN EXISTING PHARMACY?	(Y/N)	IF YES, PREVIOUS CORPORATE NAME OR PROVIDER ID	

SOFTWARE VENDOR / VERSION #	PHARMACY LICENSE NUMBER	USUAL AND CUSTOMARY DISPENSING FEE(S)

BUSINESS ADDRESS

ADDRESS (NUMBER, STREET)	CITY/TOWN	PROVINCE	POSTAL CODE

TELEPHONE		FAX	

CONTACT INFORMATION

CONTACT NAME	CONTACT TELEPHONE NUMBER	CONTACT EMAIL ADDRESS

BANKING INFORMATION

NAME OF ACCOUNT HOLDER		
NAME AND ADDRESS OF FINANCIAL INSTITUTION		
BANK NUMBER	TRANSIT NUMBER	ACCOUNT NUMBER

VOID CHEQUE OR PRE-AUTHORIZED DEBIT FORM FROM BANKING INSTITUTION ATTACHED ☐

PHARMACY AGREEMENT

I understand that my registration with CBP is subject to the terms outlined in the Pharmacy Agreement. This Agreement is available under Providers at www.cbproviders.ca

INITIAL HERE: _____

By registering with CBP, the Pharmacy agrees to submit a claim to the CBP program in an amount not to exceed the lower of either (1) the amount it would charge to its cash paying customers paid or (2) the amount that the Pharmacy would have charged any other third party (excepting contractual agreement between the Pharmacy and another third party). CBP will make payments for valid prescriptions into the designated bank account maintained by the Pharmacy on the 15th and 30th of the month in which the Pharmacy has submitted the applicable claim to CBP for payment. The payment will include all claims up to two (2) days prior to the payment.

SIGNATURE	DATE (mm/dd/yyyy)
SIGNATORY NAME	TITLE