Department of Health and Community Services
Newfoundland and Labrador Prescription Drug Program

Newfoundland and Labrador Prescription Drug Program (NLPDP) Participation Application

Section I: Provider Information

Provider Name (Proper name of sole proprietorship, partnership or corporation)		
Pharmacy Trade Name (if different)		
NLPDP Provider Number (For office use only)		
NL Pharmacy Board Number		
Mailing Address	Street / P.O. Box Number	
	City / Town	
	Province	
	Postal Code	
	Telephone	
	Facsimile	
E-mail address (if applicable)		

Section II: Computer Information

Communication Capabilities	High Speed Service Provider	
Pharmacy Software	Vendor	
	Version	

Section III: Direct Deposit Information

The attached Direct Deposit Request Form must be completed for direct deposit of NLPDP claim payments.

Section IV: Usual and Customary Charges Information

Please indicate the current charges to Seniors Citizens Drug Subsidy Program beneficiaries of your pharmacy as their co-pay.

Professional Fee (indicate amount charged)	

Section V: Declaration

The Provider shall:

- Not make any further claim, beyond the required co-pay, against any person with respect to any entitled service for which payment has been made by the Newfoundland and Labrador Prescription Drug Program (NLPDP);
- Submit, where possible, all claims for payment under the NLPDP electronically;
- Adhere to the provisions of any agreements between the Government of Newfoundland and Labrador and the Pharmacists' Association of Newfoundland and Labrador, which may be validly in force from time to time;
- Give 14 calendar days written notice to NLPDP of any changes to its usual and customary charges; and
- Give at least 30 days prior written notice of the intent to cease participation in NLPDP.

By signing this Application:

- I acknowledge my participation in the NLPDP as offered by the Government of Newfoundland and Labrador;
- I indicate that I shall comply with the Pharmaceutical Services Act and the Regulations made under it, including any policies and terms and conditions set by the Minister responsible in the administration of that Act and its Regulations, and I shall at all times abide by all applicable federal and provincial

legislation relating to the practice of pharmacy, as well as the by-laws and codes of practice set by my relevant governing bodies; and

- I acknowledge that the Drug Utilization Review Software, provided by First Databank, and used in the NLPDP adjudication system, including without limitation the warning messages and recommendations provided by it when filling a prescription, are provided as supplemental information only and are not intended to replace or substitute the professional judgment of the health care professionals involved in providing services to NLPDP beneficiaries.

_____	_____
Name of Pharmacist-in-Charge (Please print)	Signature of Pharmacist-in-Charge
_____	_____
Name of Witness (Please print)	Signature of Witness

Dated at _____ this _____ day of _____, 20_____.

Note

If and when this application is approved, a six digit Provider Number will be assigned to enable the provider to submit claims for payment under the NLPDP. This Provider Number must be quoted on all correspondence and electronic claim submissions submitted to the Program.

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Direct Deposit Request

Pharmacies can select the method for receiving their drug claims payments. Direct deposit is an optional service offered by the NLPDP where pharmacies can choose to have the payment deposited in a Canadian funds account at any chartered bank, trust company, credit union, or other financial institution in Canada. For those pharmacies that do not opt for direct deposit, cheques will be issued to the mailing address on file.

Payment will be deposited into the account within seven calendar days after the date indicated on the statement. Please refer to the NLPDP payment schedule for Direct Deposit payment dates.

To have the NLPDP deposit drug claims payment directly into an account at a financial institution, please complete this form and return it to NLPDP.

If you already have the direct deposit service then it is not necessary to complete this form unless you wish to change or stop the service.

Section A: Intent

The information provided on this request form is for (please indicate only one):

☐ Starting direct deposit

☐ Changing direct deposit information

☐ Stopping direct deposit (DO NOT COMPLETE SECTION B IF YOU CHECK THIS BOX)

Section B: Direct Deposit Routing Number

Financial Institution	Name	
	Address	
	Telephone Number	( )
Account Information	Branch number (5 digits)	
	Institution number (3 digits)	
	Account number	
	Name(s) of account holder(s)	

Attached to this form must be a voided cheque or deposit slip indicating the same information.

Section C: Conditions

- This authorization will only be used to directly deposit those payments indicated.
- If payment cannot be deposit directly in the account then a cheque will be mailed the pharmacy's address on file.
- The account must hold Canadian funds at a financial institution in Canada.
- Changes to the direct deposit information will be accepted only when a new direct deposit request form is received. To ensure correct payment, please allow one-week prior notice for any changes.

Section D: Declaration

I, as the person entitled to receive the above-noted payment, and in lieu of my receiving a cheque for the same from NLPDP, hereby authorize Newfoundland and Labrador Prescription Drug Program to deposit, until further notice, the payment described above into my account, as noted herein, by means of direct deposit.

_____ _____

Name of Pharmacist-in-Charge/Owner (Please print) Signature of Pharmacist-in-Charge/Owner

Dated at _____ this _____ day of _____, 20_____.

P.O. Box 8070, Station 'A' St. John's NL Canada A1B 4A6
t: 709.753.3615 | f: 709.739.2929