

Nova Scotia Seniors' Pharmacare Program

Billing Choices Form

This form tells us how you want to make payments to the Nova Scotia Seniors' Pharmacare Program. Please indicate your choice below.

Resident Information

Last Name	First Name	Health Card Number

Billing Choices

Option 1: Receive a paper invoice

If you choose this option, we will send you an invoice with instructions.

Please choose one of the following:

I wish to get an invoice and pay each month.

I wish to get an invoice and make one payment for the whole year

Option 2: Have payments withdrawn directly from your bank account

If you choose this option, payments will be withdrawn from your bank account on the same day of each month.

To set up this option you must do all of the following:

Send us a blank cheque with "VOID" written on it or a Preauthorized debit form.

Choose the day of the month (**from the 1st to the 28th only**) that you want the money be withdrawn: _____.

*If no date is chosen, the withdrawal date will default to the 1st of the month.

Sign the Pre-Authorized Debit (PAD) Plan agreement located on the reverse of this form.

Note: When payments are made to the Program, your health card number is used as your unique account number. Every effort is made to protect your private information. **If you do not want your health card number sent to the financial institution of your choice, you can submit a cheque/money order with the invoice to the Nova Scotia Seniors' Pharmacare Program.**

Pre-Authorized Debit (PAD) Plan Agreement:

I/We, the undersigned, authorize Nova Scotia Seniors' Pharmacare, and the financial institution designated (or any other financial institution I/we may authorize at any time) to begin deductions of a variable amount as per my/our instructions for monthly regular recurring payments for payment of all charges arising under my/our Nova Scotia Seniors' Pharmacare account(s). Regular monthly payments for the full amount of all charges arising under my/our Nova Scotia Seniors' Pharmacare account(s) will be debited to my/our specified account on the same day of each month. Nova Scotia Seniors' Pharmacare services are provided for personal use.

I/We agree to promptly inform Nova Scotia Seniors' Pharmacare, in writing using the contact details below, of any changes to the bank account information provided, in which case I/we acknowledge that this PAD Agreement shall remain in full force and effect with the updated bank account details. I/We confirm authority under the terms of the bank account agreement with my/our financial institution to authorize the debits under this PAD Agreement and that all persons whose signatures are required to sign on the bank account have signed or otherwise authorized this PAD Agreement.

I/We acknowledge that Medavie Blue Cross is a third party administering the PAD Agreement for amounts owing by me/us to Nova Scotia Seniors' Pharmacare. This authority is to remain in effect until Nova Scotia Seniors' Pharmacare has received written notification from me/us of its change or termination, which I/we may provide at any time. This notification must be received at least thirty (30) calendar days before the next debit is scheduled at the address provided below. I/We may obtain a sample cancellation form, or more information on my/our rights to cancel a PAD Agreement at my/our financial institution or by visiting www.payments.ca.

I/We understand that revocation of this PAD Agreement does not terminate, cancel, reduce, or otherwise affect my/our obligations to Nova Scotia Seniors' Pharmacare, and that this PAD Agreement applies only to the method of payment. I/We acknowledge that I/we will have to make alternate payment arrangements acceptable to Nova Scotia Seniors' Pharmacare if I/we revoke authorization for PADs but continue to have amounts owing on my/our Nova Scotia Seniors' Pharmacare account. Nova Scotia Seniors' Pharmacare may also cancel this PAD Agreement on not less than 5 calendar days' notice to me/us in accordance with the Rules of Payments Canada. **Nova Scotia Seniors' Pharmacare may not assign this authorization, whether directly or indirectly, by operation of law, change of control or otherwise, without providing at least 5 calendar days prior written notice to me/us.**

I/We have certain recourse rights if any debit does not comply with this agreement. For example, I/we have the right to receive reimbursement for any debit that is not authorized or is not consistent with this PAD Agreement. To obtain more information on my/our recourse rights, I/we may contact my/our financial institution or visit www.payments.ca.

I/We waive the right to receive pre-notification of the amount of any PAD and agree that I/we do not require advance notice of the amount of the PADs before the debit is processed. I/We also agree that a Confirmation of this PAD Agreement will be provided to me/us within 5 calendar days after the first PADs.

Authorized Signature(s) _____ **Date:** _____

Submit Your Form (Signature not required if submitting through your MSI online account)		
Online: https://novascotia.ca/dhw-pharmacare-14	By mail: Nova Scotia Seniors' Pharmacare Program PO Box 9322 Halifax NS B3K 6A4	By fax: 902-468-9402

Questions? Call 902-429-6565 or 1-800-544-6191 (toll-free in Canada). Please have your Nova Scotia Health Card Number ready.
Email us at SeniorsPharmacare@medavie.bluecross.ca and we will respond by email.
Email should not be used when sharing personal/confidential information.

The personal health information submitted above is protected by the *Personal Health Information Act* and is only collected, used, retained, and disclosed to process your request unless otherwise authorized by the legislation or with your express consent. This information is collected under the authority of the *Health Services and Insurance Act*, or the *Fair Drug Pricing Act* to administer Nova Scotia's health insurance and drug programs.