Alberta Government

Change of Vendor Request Form

Alberta Aids to Daily Living (AADL) Program

The information on this form is being collected and used by Alberta Health pursuant to sections 20, 21 and 22 of the *Health Information Act*, sections 33 and 34 of the *Freedom of Information and Protection of Privacy Act* (FOIP) and the Alberta Aids to Daily Living and Extended Health Benefits Regulations for the purpose of changing a vendor to obtain an AADL benefit. If you have any questions about the collection of this information, you can contact the Alberta Aids to Daily Living Program at 10th Floor Milner Building, 10040 – 104 Street NW, Edmonton, Alberta T5J 0Z2; Telephone: 780-427-0731, Fax: 780-422-0968.

Return this form to: AADL, 10th Floor Milner Building, 10040 – 104 Street NW, Edmonton, Alberta T5J 0Z2; Fax: 780-422-0968.

Type of Benefit: _____

Your signature on this document acknowledges you:

- **Agree to inform your current vendor of the vendor change.**
- **Medical/surgical clients are aware the change of vendor will start on the next AADL two month benefit period (vendor changes are effective on the first day of January, March, May, July, September and November.)**
  NOTE - Medical/Surgical clients: Continue to purchase all diapers, pads, liners, catheters, and ostomy supplies from your current vendor until the vendor change is completed.
  NOTE - Mobility clients: A change of vendor can only be done if you have not received the equipment or have arranged with AADL to refund your current vendor.
  NOTE – Clients with authorizations for compression garments may change vendors at any time while their authorization is active.

Please complete the following information and mail or fax to AADL:
I authorize AADL to change my vendor from

_____ to _____
Name of Current Vendor | Name of New Vendor

My Authorization Number is: _____ (contact your current vendor or authorizer if unknown).

Your new vendor will need this number in order to provide your AADL benefits.

My new vendor number is _____ Vendor will provide).

AADL Client Information

_____ | | | | | | - | | | | |
Name (Please Print) | Personal Health Care Number

If AADL has any questions or concerns I can be reached at _____
Telephone number with area code

Consent

You or your legal representative (e.g. person with your power of attorney, a guardian/trustee) must sign and date this form.

_____ X_____ _____/____/____
Print Name (Yours or Legal Representative's) | Signature (Yours or Legal Representative's) | Date (YYYY/MM/DD)

Revised December 2018