

THE INFORMATION BELOW MUST BE FILLED OUT IN ITS ENTIRETY TO BE REGISTERED

- If you have **more than one office**, a separate request form must be completed for each office.
- For offices with **more than one provider**, each person who bills under his/her own practice should complete a separate form.

Action requested

Initial set up* **Change***

*Please indicate effective date _____

Provider information

Legal name of the individual provider or clinic

Operating/practice name *(if different than legal name)*

Business address

City

Province

Postal code

Phone number

Fax number

Banking information

Bank account holder's name

Attach cheque marked "VOID" here or have your financial institution complete the following bank account information

Name of financial institution

Address of financial institution

Branch (transit) number
(five digits)

Bank number
(three digits)

Account number
(maximum 12 digits)

Please provide teller stamp here

Authorization

I hereby authorize Alberta Blue Cross to initiate direct deposit of funds to the account noted above.

Signature _____

Date _____

Please mail or fax your completed form to

**Alberta Blue Cross
Health Provider Services
10009 108 Street
Edmonton, AB T5J 3C5
Fax: 780-498-3544**

For assistance with this form or more information about online health services claims submission, please call

**780-498-8083 (Edmonton and area)
1-800-588-1195 (toll free)**

Please note: Alberta Blue Cross has the right to refuse or remove direct deposit of funds at any time.

