ALBERTA BLUE CROSS®

HEALTH SERVICES PROVIDER APPLICATION FOR DIRECT DEPOSIT OF FUNDS

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

Please ensure the following banking information is accurate and clearly legible as it will be added to our system as it appears on this form.

Bank account holder's name		
Name of financial institution	Address of financial institution	
Branch (transit) number *(five digits)*	Bank number *(three digits)*	Account number *(maximum 12 digits)*

AUTHORIZATION

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

Signature _____ Date _____

Please fax your completed form to **Alberta Blue Cross** **Health Provider Services** **Fax: 780-498-3544** **Toll free fax: 1-855-498-3546**	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.

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