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

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 *(5 DIGITS)*	BANK NUMBER *(3 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:	For assistance with this form or more information about online health services claims submission, please call:
Alberta Blue Cross **Health Provider Services** **10009-108 Street** **Edmonton, AB T5J 3C5** **Fax: 780-498-3544**	**Edmonton and area 780-498-8083** **Toll free 1-800-588-1195**

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