

The information on this form is being collected and used by Alberta Health pursuant to sections 20, 21(1) and 27 of the *Health Information Act* and section 33(c) of the *Freedom of Information and Protection of Privacy Act* for the purpose of enrolling you for programs or benefits funded by Alberta Health. The confidentiality of this information and your privacy are protected by the provisions of the *Health Information Act* and the *Alberta Health Care Insurance Act*. If you have any questions regarding the collection or use of this information, please contact an Alberta Health representative toll-free within Alberta at 310-000 then 780-422-1522 or by mail at Alberta Health, Claims Management Unit, PO Box 1360 Stn Main, Edmonton, AB T5J 2N3.

For AH Office Use Only

Important: Alberta Health must be notified when you move

Comments (as applicable)

NOTE: If you change your financial institution or close your direct deposit account, please update your account information as soon as possible.

Practitioner Information (Complete the identifier to be used for this banking information)

Practitioner Identifier OR Professional Corporation (PC) or Clinic ULI

 OR

Last Name

First Name

Middle Name

Professional Corporation or Clinic Name

Street Address

City or Town

Province

Postal Code

Banking information to be applied to:

BA Number

Effective Date yyyy-mm-dd

For Direct Deposit Attached is:

☐

a void cheque

☐

documentation from a financial institution indicating bank, branch transit, and account number.

Bank Information (To be completed by the financial institution if not attaching a void cheque or bank documentation)

Name of Bank, Credit Union, etc.

Street Address

City or Town

Province

Postal Code

Bank Transit/Branch Number

Bank Number

Account Number

Account Holder Name

Bank Stamp:

If you **have a cheque** for the account, send one with "VOID" written on the front OR

If you **do not** have a cheque for the account, take this form to where the account is located. Have a bank officer sign and stamp to verify the above banking information or provide the information on their own form.

Telephone Number

Date yyyy-mm-dd

Financial Institution Officer's Signature

Practitioner Authorization (This section must be completed)

I, the practitioner, authorize Alberta Health to deposit payments into the account shown above. I understand I must notify Alberta Health immediately if the account changes or is to be closed.

Contact Number

Name

Date yyyy-mm-dd

Practitioner Signature

BA Contract Holder Authorization (This section must be completed)

I, the Business Arrangement Contract Holder, verify that the information provided in this form is correct and that I am able to authorize the changes identified above regarding banking information for the business arrangements shown above. I understand I must notify Alberta Health immediately if the account changes or is to be closed.

Contact Number Name Date yyyy-mm-dd BA Contract Holder/ARP Representative Signature

Send completed forms to the Professional and Facility Management Unit via fax to 780-422-3552

or via email to Health.PracForms@gov.ab.ca.

Refer to the instructions for help completing this form. If you need further assistance, call 780-422-1522 in Edmonton, or toll-free within Alberta at 310-0000, then 780-422-1522.