SASKATCHEWAN BLUE CROSS®

516 2nd Avenue North, PO Box 4030
Saskatoon, SK S7K 3T2

DIRECT DEPOSIT AUTHORIZATION: PROVIDER

☐ New
☐ Change

Note: This form only authorizes EFT reimbursement for Health and/or Dental benefits at this time.

INSTRUCTIONS:

1. Complete this Direct Deposit Authorization Form in full
2. Attach a copy of a void cheque **or** direct deposit form from your financial institution
3. Return form and attachments to Saskatchewan Blue Cross using one of the following methods:
Mail: PO Box 4030, Saskatoon, SK S7K 3T2
Fax (H&D Claims): (306) 667-5860

PAYEE INFORMATION

Pay To: ☐ Provider ☐ Clinic/Head Office

Provider Name | Provider Number (If known) | Clinic/Business/Head Office Name (If applicable)

Mailing Address | City | Province | Postal Code

Email Address | Phone Number

BANK ACCOUNT INFORMATION

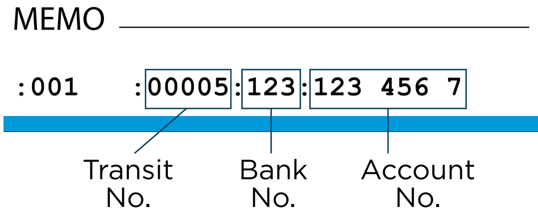
Financial Institution

Address (Street, City, Province, Postal Code)

Branch Transit Number ______

Bank ID Number ______

Account Number ______



Insert the numbers found at the bottom of your cheques or direct deposit slip.

AUTHORIZATION

I, the provider listed above of the clinic/business listed above, am the(an) authorizing signing officer(s) for the purpose of completing this direct deposit form as the applicant(s).

I hereby authorize Saskatchewan Blue Cross to directly deposit payments to the bank account identified above and on the attached void cheque or direct deposit slip. If applicable, this authorization replaces all previous direct deposit instructions. I also authorize Saskatchewan Blue Cross to withdraw funds required to correct amounts that may have been deposited in error, on the understanding that I will be notified of the adjustment prior to any withdrawal.

I understand that the information I have given or may provide in the future, as well as any other information currently held by or given to Saskatchewan Blue Cross and/or its agents may be collected, used, maintained and disclosed for the purposes of determining services including but not limited to coverage, adjudicating or paying claims, administering products and services, audit and investigation, confirmation of my identity, maintaining my relationship with Saskatchewan Blue Cross and helping to develop and recommend suitable products and services to me where applicable.

I understand that the information given to Saskatchewan Blue Cross will be kept confidential and secure. I understand that consent may be revoked at any time in writing; however, if consent is withheld or revoked, any of the above-mentioned services may be revoked. I understand why this information is needed and am aware of the risks and benefits of consenting or refusing to consent to its disclosure. For additional information regarding the privacy policies of Saskatchewan Blue Cross and/or the collection, use or disclosure of information, please visit www.sk.bluecross.ca or call 1-800-667-6853.

Signature of Provider | Signature of Authorized Signing Officer for Named Clinic/Business (If applicable)

Name (Print) | Name (Print)

Date (YYYY-MM-DD) | Date (YYYY-MM-DD)

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