ELECTRONIC PAYMENT AUTHORIZATION

Head Office
200 Quikcard Centre
17010 103 Avenue
Edmonton AB T5S 1K7

p 780.426.7526
f 780.425.1625
1.800.232.1997

Provider Information

Provider Name _____

Provider # _____

Address _____
Unit / Street City Province Postal Code

Telephone _____ Fax _____ Email Address _____

☐ Please use this email address for payment notification.

Banking Information

Enter all the digits along the bottom of your cheque after the cheque number itself.

Transit Number ☐☐☐☐☐ Bank Number ☐☐☐ Account Number ☐☐☐☐☐☐☐☐☐☐☐

Please attach a void cheque.

Authorization

I authorize Alberta Dental Service Corporation (ADSC) to credit my account indicated for payments payable by Alberta Dental Service Corporation in respect of treatment claims.

Each payment shall be the same as if I had personally received a cheque authorizing the bank to pay me as indicated and to credit the amount specified to my account.

I will notify Alberta Dental Service Corporation promptly in writing if I move the account from one bank or branch to another, or if there is any other change in the account.

This authorization may be cancelled at any time upon written notice by me to Alberta Dental Service Corporation.

Any delivery of this authorization to Alberta Dental Service Corporation constitutes delivery by me to the bank.

I am the person who is required to sign on the above account.

I have kept a signed copy of this authorization form.

☐ I authorize ADSC to credit my account indicated for payments payable by ADSC in respect of treatment claims.

☐ I authorize Quikcard Solutions Inc to credit my account indicated for payments payable by Quikcard in respect of treatment claims.

☐ I have attached a void cheque.

_____ Provider's Signature

_____ Date