



### PROVIDER ELECTRONIC DEPOSIT AUTHORIZATION

**INSTRUCTIONS:** Please do not forget to sign and date this form.

**IMPORTANT:** This form will be returned to you if it is incomplete or unsigned.

**COMPLETED FORM:** Can be mailed, faxed or emailed to [claims@adsc.org](mailto:claims@adsc.org)

### 1. Provider Information

Name \_\_\_\_\_ Provider ID # \_\_\_\_\_ Phone # \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

*Please use this email address for payment notifications.*

### 2. Banking Information

Name of Bank \_\_\_\_\_

Branch Address \_\_\_\_\_ City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Branch Number \_\_\_\_\_ Institution Number \_\_\_\_\_ Bank Account Number \_\_\_\_\_

***\*Please attach a void cheque with this form\****

### 3. Disclaimers

**PRIVACY NOTICE:** The information requested in respect of this form is required by ADSC for benefits administration purposes. For these purposes ADSC will, where necessary, collect from and exchange information with others. For more information, consult ADSC's privacy policy or contact ADSC by phone or mail.

**AUTHORIZATION:** I authorize ADSC to credit the account identified (the "Account") for payments administered by ADSC in respect of treatment claims. Each payment shall be the same as if I had personally received a cheque from ADSC and deposited it to the Account. I will update the Account promptly if I move the Account from my 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 ADSC. Any delivery of this authorization to ADSC constitutes delivery by me to my Bank. I am the person who is authorized to sign on the Account.

Signature of Provider \_\_\_\_\_

Date \_\_\_\_\_