PROVIDER EFT FORM

CANADIAN BENEFIT PROVIDERS

PAYEE INFORMATION

PROVIDER NAME (PAYEE)			
PAYEE ADDRESS (NUMBER, STREET)	CITY/TOWN	PROVINCE	POSTAL CODE
CDA Unique ID # (Mandatory for Dental Offices)			

PAYMENT INFORMATION

CONTACT NAME (First Name, Last Name)	
EMAIL (Mandatory)	

*Required: VOID CHEQUE OR PRE-AUTHORIZED DEBIT FORM FROM BANKING INSTITUTION ATTACHED ☐

PAYEE AUTHORIZATION

By signing this application, I certify that the information provided on this form and proposal is complete and accurate.

SIGNATURE	DATE (mm/dd/yyyy)
SIGNATORY NAME	TITLE

Please submit completed forms to CBP by Fax or Email

ProHealth Help Desk
T: 780.944.9166 ext 280
E: helpdesk@cbproviders.ca

Help Desk Hours
Monday – Friday: 7 am – 6pm MST
Saturday: 9 am – 4 pm MST
Sundays and Holidays: Closed

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