Direct deposit information

PHYSICIANS

This form is used to provide direct deposit information for physician payments.

A personalized void cheque or a bank confirmation letter (dated within the last five years) must accompany this form.

This form can be securely faxed to 403.228.5845. Email is not a secure method of communication, but you can email this form to finance@cwcpcn.com at your own risk.

Physician name	
Professional Corporation *(if applicable)*	
Institution number *(three digits)*	
Transit number *(five digits)*	
Account number	
Remittance email	

Physician name: _____

Physician signature: _____ Date: _____

Payment requests are to be submitted directly to finance@cwcpcn.com within 30 days of the services provided, and within 15 days of the end of our fiscal year (March 31st).

Approved payments will be made by EFT using Plooto within 30 days.

Please note that changes to direct deposit information are subject to verification procedures to prevent unauthorized changes.