

PROVIDER EFT FORM



PAYEE INFORMATION

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

PAYMENT INFORMATION

CONTACT NAME (First Name, Last Name)	
EMAIL for EFT notification (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 email at helpdesk@cbproviders.ca.

CBP Help Desk

T: 780.944.9166

F: 844.944.9168

T (toll free): 855.944.9166

E: helpdesk@cbproviders.ca

Help Desk Hours

Monday – Friday: 7 am – 6pm MST

Saturday, Sundays and Holidays: Closed