# DIRECT DEPOSIT FORM

Audit & Claims Integrity Division
Insured Programs

To receive assistance, applicants of the Medical Transportation Assistance Program are required to enroll in the government's direct deposit program by completing and submitting this form.

## PATIENT INFORMATION

| | |
|---|---|
| Surname | First Name |
| MCP Number | Date of Birth |
| Daytime Telephone Number | Email address (if applicable) |

## MAILING ADDRESS

| | | |
|---|---|---|
| Street / P.O. Box | | |
| City / Town | Province | Postal Code |

## ELECTRONIC PAYMENT INFORMATION

Bank Name and Address

| Bank Institution Number | Bank Transit Number |
|---|---|

Account Number

Name of Account Holder

Printed Name: _____

Signature: _____

Date: _____

**You must attached a void cheque, or correspondence from Financial Institution, or have Financial Institution complete this section.**

Bank Officer's Signature: _____

Printed Name: _____

Title: _____

*Financial Institution Stamp Here*

**PLEASE RETURN COMPLETED FORM TO:**

**Department of Health & Community Services**
**Insured Programs**
**PO Box 8700**
**Confederation Building, West Block**
**St. John's NL A1B 4J6**

**PRIVACY NOTICE**
Personal health information collected, used, disclosed, and safeguarded is in accordance with the *Personal Health Information Act* (PHIA). If you have any questions about the collection or use of this information please contact our office. The Department of Health and Community Services privacy statement can be found at www.health.gov.nl.ca/health/PHIA.