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:

Medical Transportation Assistance Program
Department of Labrador Affairs
PO Box 8700
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 at 1-877-475-2412. Additional information on the Personal Health Information Act can also be found at www.health.gov.nl.ca/health/PHIA