Ontario

Ministry of Health and Long-Term Care

Application for Direct Bank Payment

Confidential when completed

Transaction type
☑ New ☐ Change

A. Personal Data *(Show either the Group **or** Physician/practitioner number)*

Your registration no.	or	<-- *Enter your OHIP Billing Number here*

Group name Surname and initials *(please print)*

B. Authorization for Direct Bank Payment from the Ministry of Health

I/We hereby authorize the Ministry of Health to make direct bank payment in the account indicated.

Solo Registration

Applicant's signature	Name of signee or applicant *(please print)*	*(dd/mm/yyyy)* Date	Telephone no.

~~Group Registration~~ N/A

Two signatures are required if the application is for a group with two or more members. One of the signatures will be accepted from a non-group member, i.e. group administrator as designated by physician member(s) of the group.

Applicant's signature *(must be an*	Name of signee or applicant *(please print)*	*(dd/mm/yyyy)*	Telephone no.

Applicant's signature	Name of signee or applicant *(please print)*	*(dd/mm/yyyy)*	Telephone no.

C. Payment Data

*Attach a blank voided cheque, from the financial institution where you bank, with the fully micro-encoded branch, institution and account numbers. Note: Payment data will be used for **Direct Bank Payment.***

Bank account in the name of

Collection of the information on this form is authorized under the Health Insurance Act, R.S.O., 1990, c. H. 6, Sections 21 to 24 and 35. It will be used to electronically deposit payments and as part of a data base. For information about collection practices, contact the Director, Provider Services Branch* or the Director of your local Ministry of Health office.

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