

Fax Cover Page

To: **TELUS Health Solutions
Provider Services**

Fax number: **1 866 840-1466**

Please find enclosed the completed Amendment to the Provider Agreement confirming that we wish to expand the current TELUS bill submission services to cover electronic claims submission to private group insurers.

(Name)

Amendment to Provider Agreement

I hereby wish to enroll to the TELUS Health eClaims Portal, and accept that the Provider Agreement that I have previously signed with TELUS be expanded to cover claims submission to private insurance companies, in addition to the current bill submission to the Workplace Safety and Insurance Board of Ontario (WSIB). I also recognize that the use of the TELUS Health eClaims health provider portal is free of charge to any healthcare providers that adhere to the services. This approval shall constitute an amendment to the Provider Agreement.

I am an Independent Practitioner **OR** I am a Clinic or Organization

Name of Independent Practitioner or Clinic/Organization (PLEASE PRINT)

WSIB Billing Number or TELUS Provider Number *note: 9-digit number starting with 1000*

Address, City, Province, Postal Code

Email Address

Authorized Signature of Service Provider (I have the authority to bind the provider)

Date (dd/mm/yyyy)

IMPORTANT: If you are a clinic with multiple practitioners working in the clinic, you are **required** to confirm or update all the provider(s) practicing within your clinic/organization. Please complete the associate provider(s) profile form on the next page and submit it along with this amendment to have your practitioner(s) registered on our network.

**Should you have any questions, please contact TELUS Health Solutions at 866 240 7492.
Please fax the completed form to:**

TELUS Health Solutions

Attn: Provider Services Representative

Fax: 866 840-1466

Email: provider.registry@telus.com

Associate Provider(s) Profile

Name of Practitioner: _____

Provider Profession (e.g. chiropractor, physiotherapist, etc.): _____

Provider College/Professional Registration Number: _____ (for health professionals)

Name of Practitioner: _____

Provider Profession (e.g. chiropractor, physiotherapist, etc.): _____

Provider College/Professional Registration Number: _____ (for health professionals)

Name of Practitioner: _____

Provider Profession (e.g. chiropractor, physiotherapist, etc.): _____

Provider College/Professional Registration Number: _____ (for health professionals)

Name of Practitioner: _____

Provider Profession (e.g. chiropractor, physiotherapist, etc.): _____

Provider College/Professional Registration Number: _____ (for health professionals)

Name of Practitioner: _____

Provider Profession (e.g. chiropractor, physiotherapist, etc.): _____

Provider College/Professional Registration Number: _____ (for health professionals)

Name of Practitioner: _____

Provider Profession (e.g. chiropractor, physiotherapist, etc.): _____

Provider College/Professional Registration Number: _____ (for health professionals)

Print