THE CANADIAN DENTAL HYGIENISTS ASSOCIATION
L'ASSOCIATION CANADIENNE DES HYGIÉNISTES DENTAIRES

CDHA-ACHDnet™ Electronic Billing Enrollment Form

This information will allow CDHA to provide full CDHA-ACHDnet™ services via instream CLAIMS™ and to properly administer that service. Please fill out a new subscription agreement form for each office in which you work (included below).

DENTAL HYGIENIST INFORMATION

*Name of Subscribing Dental Hygienist: ______________________________

*Language of choice: English ❑ French ❑

CDHA Member no. (*if known*): ______________________UIN (9 digits): 2 0 2 ___ ___ ___ ___ ___ ___ *(If known)*

*Member of Provincial/Territorial Dental Hygienist Association YES ❑ NO ❑

If **YES**, please indicate your Provincial Registration (License) No.: ______________

*Dental Hygienist's Business Email address: ______________________________

*Private Email address (Optional): ______________________________

CDHA-ACHDnet™ Office No.: ___ ___ ___ H *(If unknown or not yet assigned, please leave blank)*

Please indicate all CDHA-ACHDnet™ office numbers the Dental Hygienist is currently submitting claims from:

(excluding the office no. listed above)

1. __________________ 2. __________________ 3. ____________________ 4. ____________________

Will the Dental Hygienist soon be leaving another office location? YES ❑ NO ❑

**If YES*, please indicate CDHA-ACHDnet™ office number:* ___ ___ ___ H Date Effective: ______________________

OFFICE INFORMATION

*Contact Person(s)/Owner: ______________________________

If incorporated, please give name of incorporated company ______________________________

*Address: ______________________________

*City: ____________________________ *Province: ______________________ *Postal Code: __________________

*Office Telephone No.: (_______) ______________________

*Office Email address: ______________________________

(Important CDHA-ACDHnet™ and instream CLAIMS ™ administrative notices will be emailed here)

*Email instream CLAIMS™ Digital Certificate issuance/expiry notices to my office email listed above: YES ❑ NO ❑

*If **NO**, please enter the email address:* ______________________________

*Name of the software vendor providing your dental hygiene office system? ______________________________

* ***Mandatory***

*** instream CLAIMS™ CERTIFICATE PASSWORD DELIVERY**

DELIVERY CONSENT

Authorizing mail delivery release instream CLAIMS ™ of any security liability. The named Hygienist acknowledges that this method of transport may not be secure and the personal information contained in this communication may ultimately be viewed by a third party or lost in transport.

This authorizes instream CLAIMS ™ to send password information upon request from an authorized contact from this day forward.

Address: ____

City: ___________________________ Province: ______________________ Postal Code: ___________________

Account Contact(s) that can obtain the password for your INSTREAM CLAIMS™ Digital Certificate:

____

PERSONAL INFORMATION CONSENT

In order to provide you with CDHA-ACHDnet™ & instream CLAIMS™ transaction and messaging services and the issuance of an instream CLAIMS digital trust certificate, it is necessary for the Canadian Dental Hygienists Association (CDHA) to collect, retain, use, disclose and share your personal information with the following parties: instream CLAIMS TM, your licensing and regulatory authority (college), adjudicators and payors of health benefit claims, practice management software vendors, laboratories and other services providers (collectively, Third Parties).

I authorize CDHA and these Third Parties to collect, retain, use, disclose and share my personal information, and any other information necessary to provide the services hereunder to you. CDHA's privacy statement is available at www.cdha.ca.

❑ I acknowledge that I have read the subscription agreement (available on our website: http://www.cdha.ca/cdha/The_Profession_folder/Independent_Practice_folder/Claim_Forms__UIN_Application_folder/CDHA/The_Profession/Independent_Practice/Claim_Forms.aspx?hkey=561d8251-64af-4907-84de-0cd0f126821b) and agree to the Terms and Conditions. This Agreement shall be effective as of the date of execution, namely the:

Date: __________/_________/_________ *Dental Hygienist Signature: ______________________
Month *Day* *Year* ****NO STAMP/DIGITAL PLEASE****

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Send applications completed in full by mail, fax OR email to:

Canadian Dental Hygienists Association
By mail: 1122 Wellington St W, Ottawa, ON K1Y 2Y7
By fax: 613-224-7283
By email: info@cdha.ca

Questions? Call the CDHA at 1-800-267-5235
Please send your form by Fax: 613-224-7283 or Email: info@cdha.ca

FOR CDHA USE ONLY:

Start Date: _______/_______/______ CDHA ID ________________ Faxed to instream: ______/_______/______