

ITRANS Claim Service ROC - Denturist

**PLEASE FILL OUT AND
FAX TO: 613-736-8030**

DENTURIST INFORMATION *MANDATORY*

Denturist Name: _____

Provider ID (9 digit DACnet™ unique ID#): _____

Critical ITRANS Notifications Email Address:: _____

OFFICE INFORMATION *MANDATORY*

Address: _____

STREET

CITY

PROVINCE

POSTAL CODE

Site ID (4 character DACnet™ Office ID): _____ Telephone: _____ Fax : _____

Send important ITRANS administrative notices to the following email: _____

Practice management software: _____

Authorized Contact(s): _____

↳ Person(s) that you authorize to have access to the password for your ITRANS Digital Certificate

ALTERNATE PASSWORD INFORMATION DELIVERY DESTINATION

Please mail my password information to the address listed below instead of the office address specified above.

Address: _____

STREET

CITY

PROVINCE

POSTAL CODE

Please fax my password information to the fax listed below instead of the office fax specified above.

Fax : _____

PASSWORD INFORMATION FAX DELIVERY CONSENT

I authorize Continovation Services Inc. (CSI) to send my password information to the office fax number specified above. Authorizing fax delivery releases CSI of any security liability. The named dentist 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 CSI to send password information via fax upon request from an authorized contact from this day forward.

Denturist Signature: _____ Date: _____

NO STAMPS PLEASE

Please note: Should the fax method of delivery not be authorized and an alternate password information delivery destination not specified, CSI will mail the password information to the office address.

PAYMENT OF FEES

ITRANS Claim Service annual access fee: ■ ~~\$180~~ **Introductory Offer:** \$120+ \$6 GST = \$126

VISA MasterCard Name on card (please print): _____

Account Number: _____

Expiry Date (month/year) ____ / ____

Cardholder Signature: _____

Payment by cheque made out to "Continovation Services Inc."

and mailed to the following address: 800 Industrial Ave., Unit 11, Ottawa, ON K1G 4B8

PERSONAL INFORMATION CONSENT

In order to provide you with ITRANS™ transaction and messaging services and the issuance of an ITRANS digital trust certificate, it is necessary for Continovation Services Inc. (CSI) to collect, retain, use, disclose and share your personal information with the following parties: the Canadian Dental Association, 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 CSI 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. CSI's privacy statement is available at www.continovation.com.

Denturist Signature: _____ Date: _____

MANDATORY - NO STAMPS PLEASE

MANDATORY