INTEGRANET HEALTH TPA SERVICES ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

PART I – REASON FOR SUBMISSION

Reason for Submission: ☐ New EFT Authorization
☐ Revision to Current Authorization (*e.g. account or bank changes*)

Chain Home Office Organization: ☐ Check here if EFT payment is being made to the Home Office of Chain (*Attach letter authorizing EFT payment to Chain Home Office*)

PART II – PROVIDER OR SUPPLIER INFORMATION

Name _____

Provider/Supplier Legal Business Name _____

Chain Organization Name _____

Home Office Legal Business Name (*if different from Chain Organization Name*)

Tax Identification Number: (Designate ☐ SSN or ☐ EIN) _____

Medicare Identification Number *(If issued)* _____

National Provider Identifier (NPI) _____

PART III – DEPOSITORY INFORMATION (Financial Institution)

Depository Name _____

Street Address _____

City _____ State _____ Zip Code _____

Depository Telephone Number _____

Depository Contact Person _____

Depository Routing Transit Number (*nine digit*) _____

Depositor Account Number _____

Type of Account (*check one*) ☐ Checking Account ☐ Savings Account

Please include a voided check or deposit slip or confirmation of account information on bank letterhead. When submitting the documentation, it should contain the name on the account, electronic routing transit number, account number and type, and bank officer's name signature. This information will be used to verify your account number.

PART IV – CONTACT PERSON

First Name	Middle Initial	Last Name
Telephone Number		Fax Number *(if applicable)*
Address Line 1 *(Street Name and Number)*		
Address Line 2 *(Suite, Room, etc.)*		
City/Town	State	Zip Code + 4
E-mail Address		

PART V- AUTHORIZATION

I hereby authorize the Health Plans, hereinafter called the CONTRACTOR, to initiate credit entries, and in accordance with 31 CFR part 210.6(f) initiate adjustments for any credit entries made in error to the account indicated above. I hereby authorize the financial institutions/bank named above, hereinafter called the DEPOSITORY, to credit and/or debit the same to such account.

If payment is made to an account controlled by a Chain Home Office, the Provider of Services hereby acknowledges that payment to the Chain Office under these circumstances is still covered payment to the Provider, and the Provider authorizes the forwarding of the Health Plan payments to the Chain Home Office.

If the account is drawn in the Physician's or Individuals PRACTITIONER'S Name, or the Legal Business Name of the Provider/Supplier, the said Provider or Supplier certifies that he/she has sole control of the account referenced above, and certifies that all arrangements between the DESPSITORY and the said Provider or Supplier are in accordance with all applicable Medicare regulations and instructions.

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until the CONTRACTOR has received written notification from me of its termination in such time and such manner as to afford the CONTRACTOR and the DEPOSITORY reasonable opportunity to act on it. The CONTRACTOR will continue to send the direct deposit to the DEPOSITORY indicated above until notified by me that I wish to change CONTRACTOR and updated EFT Authorization Agreement.

Signature Line

Authorized/Delegated Official Name (Print) _____

Authorized/Delegated Official Title _____

Authorized/Delegated Official Signature _____ Date _____

I understand in receiving Electronic Funds Transfers that payment may be from Federal and State funds and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.

PRIVACY ACT ADVISORY STATEMENT

Sections 1842, 1862(b) and 1874 of title XVIII of the Social Security Act authorize the collection of this information. The purpose of collecting this information is to authorize electronic funds transfers.