The CHP Group Electronic Funds Transfer (EFT) Enrollment Form

1 – Enrollment
Select your enrollment options below

◉ **New Enrollment** ○ **Change Enrollment** ○ **Cancel Enrollment** **Requested EFT Start/Change/Cancel Date:** _____

2 – Provider Information
Complete the provider information below

Provider Name | **Doing Business As (DBA) Name**

Payee Name | **Tax ID Number** | **National Provider Identifier Number**

Preference for Aggregation of Remittance Data – For example, account number linkage to Provider Identifier ◉ **Tax ID** ○ **NPI**

3 – Billing Office Contact Info
Complete the information below if different from provider

EFT Contact Name | **EFT Contact Phone** | **EFT Contact E-mail**

Technical Contact Name | **Technical Contact Phone** | **Technical Contact E-mail**

4 – Account Info
Complete the information for EFT enrollment

If you are a provider paid by your clinic as an employee, please forward this form to the person responsible for direct deposit into the clinic's account.

Name of Financial Institution | **Routing #** | **Financial Institution Phone**

◉ **Checking** ○ **Savings**

Name on Account | **Account Number** | **Account Type**

4 – Authorization Agreement
Read and sign where indicated

I hereby authorize **The CHP Group** to initiate automatic deposits to my account at the financial institution named below. I also authorize **The CHP Group** to make withdrawals from this account in the event that a credit entry is made in error. **The CHP Group** confirms it will not make withdrawals from this account for overpayments it has made to me which were identified in the normal course of business.

Further, I agree not to hold **The CHP Group** responsible for any delay or loss of funds due to incorrect or incomplete information supplied by me or by my financial institution or due to an error on the part of my financial institution in depositing funds to my account.

This agreement will remain in effect until **The CHP Group** receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Provider Services Department.

Authorized Signature (Primary Account Holder) | **Printed Name** | **Date**

Authorized Signature (Joint Account Holder) | **Printed Name** | **Date**

5 – Return This Form WITH A COPY OF A VOIDED CHECK

By Mail
The CHP Group
PO Box 278
Beaverton OR 97075-0275

ATTACH A VOIDED CHECK TO THIS FORM

By Fax 877-482-2856

ATTACH A VOIDED CHECK ON A SEPARATE PIECE OF PAPER

For Internal Use ☐ **Group Pay** ☐ **Direct Pay**

	PS	Finance	IT	F/C Review
Processed by				
Date				