The CHP Group Electronic Funds Transfer (EFT) Enrollment Form

1 – Enrollment	Select your enrollment o	ptions below				
☐ New Enrollme	ent Change Enrollment	☐ Cancel Enrollment	Requested EF	T Start/Change/Cand	cel Date:	
2 – Provider In	formation Complete th	e provider information be	elow			
Provider Name Doing Business As (DBA) Name						
Payee Name		Tax ID Number	Tax ID Number National Pr		r Identifier Number	
Preference for Aggregation of Remittance Data – For example, account number linkage to Provider Identifier \Box Tax ID \Box NPI						
3 – Billing Offic	ce Contact Info Comp	plete the information belo	w if different fro	om provider		
EFT Contact Name		FET Contact Phor	EFT Contact Phone EFT Contact			
EFT CONTACT NAME		El i Contact i noi	21 Contact Hole			
Technical Contact Name		Technical Contac	Technical Contact Phone Technical Cont		mail	
4 – Account Inf	fo Complete the informa	tion for EFT enrollment				
	ler paid by your clinic as an emp	loyee, please forward this i	form to the pers	on responsible for direc	ct deposit into the clinic's	
account.						
Name of Financial Institution		Routi	Routing #		ncial Institution Phone	
					hecking Savings	
Name on Account		Acco	Account Number		ount Type	
·						
4 – Authorizati	on Agreement Read	and sign where indicated				
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