# Electronic Funds Transfer (EFT) Enrollment Form

## ENROLLMENT

New Enrollment ☐ Change Enrollment ☐ Cancel Enrollment ☐

**Requested EFT Start/Change/Cancel Date:** _____

## PROVIDER INFORMATION

**Provider Name:** _____

**Doing Business As (DBA) Name:** _____

**Payee Name:** _____

**Tax Identification Number:** _____

**National Provider Identifier:** _____

**Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier):** Tax ID: ☐ NPI: ☐

## BILLING OFFICE CONTACT INFORMATION (if different from Provider)

**EFT Contact Name:** _____

**EFT Contact Phone #:** _____

**EFT Contact Email:** _____

**Technical Contact Name:** _____

**Technical Contact Phone # :** _____

**Technical Contact Email:** _____

## ACCOUNT INFORMATION (for EFT Enrollment)

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

**Name of Financial Institution:** _____

**Financial Institution Phone #:** _____

**Name on Account:** _____

**Routing Number:** _____

**Account Number:** _____ **Checking** ☐ **Savings** ☐

**COPY OF VOIDED CHECK IS REQUIRED- PLEASE ATTACH WITH THIS FORM**

## AUTHORIZATION AGREEMENT

I hereby authorize **Heraya Health** to initiate automatic deposits to my account at the financial institution named below.

Further, I agree not to hold **Heraya Health** 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 **Heraya Health** receives a written notice of cancellation from me or my financial institution, or until I submit a new direct deposit form to the Provider Support Services Department.

**Authorized Signature (Primary Account Holder):** _____ **Date:** _____

**Printed Name:** _____

**Authorized Signature (Joint Account Holder):** _____ **Date:** _____

**Printed Name:** _____

## ATTACH A COPY OF A VOIDED CHECK IN THE SPACE BELOW

**Please return this form to Heraya Health**

**Fax: 877-482-2856**

**Mail: Heraya Health, PO Box 278, Beaverton, OR 97075-0278**

| INTERNAL USE ONLY | |
|---|---|
| **Group Pay** ☐ | **Direct Pay** ☐ |
| **PSS Processed By:** | **Date:** |
| **Finance Processed By:** | **Date:** |
| **IT Processed By:** | **Date:** |
| **F/C Review By:** | **Date:** |