



ELECTRONIC REMITTANCE ADVICE (835) AND EFT AUTHORIZATION AGREEMENT

Please complete all applicable sections. Submit a copy of your W-9 with this completed form to us at 1908 N. Laurent, Suite 250, Victoria, TX 77901. Please note EFT payment may take up to 2 payment cycles before becoming effective.

PROVIDER INFORMATION

I wish to enroll in (choose one): [] EFT and 835/ERA [] EFT only
Provider Name (as it appears on the W-9)
Street City State Zip
Provider Federal Tax Identification Number (TIN)
National Provider Identifier (NPI)
Provider Contact Name Phone
Email Address

BANK INFORMATION

Financial Institution Name
Street City State Zip
Financial Intuition Routing Number
Type of Account at Financial Institution (choose one) [] Checking Account [] Savings Account
Provider's Account Number with Financial Institution
Reason for submission (choose one)
[] New Enrollment [] Change Enrollment [] Cancel Enrollment
Clearinghouse Name
Clearinghouse Contact Name & Phone Number

DISCLOSURE

By submitting this form, I authorize the above-named contact person to execute, implement, and perform all functions necessary for my facility to receive electronic funds transfer (EFT) payments, and (if requested) electronic remittance advice from Texas Independence Health Plan, Inc.

Printed Name of Person Submitting Enrollment
Signature of Person Submitting Enrollment
Printed Title of Person Submitting Enrollment
Submission Date