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_____