

Electronic Funds Transfer Authorization Form

PART I: TO BE COMPLETED BY PROVIDER

Request Type (circle one): **Change** **Add** **Delete**

Request Health Plan (mark "x" to indicate plan(s)): BlueCross BlueShield of South Carolina BlueChoice HealthPlan

Provider's Name:

Address:

City: *State:* *ZIP:*

Contact's Name:

Contact's Address:

City: *State:* *ZIP:*

Contact's Phone #:

E-mail Address:

Bank's Name:

Bank Account Number:

ABA Number (Routing Number): - - (i.e. 123-456-789)

Account Type:
Checking:
Savings:

If you want electronic payments for ALL locations, please check here and complete only the Federal Tax ID and NPI boxes.

If you want electronic payments for select locations, complete the Federal Tax ID and the appropriate NPI(s) in the boxes below.

Federal Tax ID: NPI(s):

To turn off Paper Remits, check here: To turn Paper Remits back on, check here:

In order to have electronic payments sent directly to your financial institution, the provider must have sole control of the account and the financial institution is subject only to the provider's instructions regarding the account.

Provider's Authorized Signature:

(Must match authorized signature on bank signature card.)

Printed Name:

Title:

Date:

PART II: TO BE COMPLETED BY FINANCIAL INSTITUTION (FI) **

Please Verify the Routing and Account Information Above

Contact's Name:

Contact's Address:

City: *State:* *ZIP:*

FI Authorized Signature **:

Printed Name:

Title:

Date:

** The FI signature represents its validation of all information related to this account provided above, including the authorized signature.

For office use only:

	Date	Initials
Received:	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Validation Completed:	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Update Completed:	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>