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 SouthCarolina ____ 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:

Account Type:

Bank Account Number: **Checking:**

ABA Number (Routing Number): - - (i.e. 123-456-789) **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:		
Validation Completed:		
Update Completed:		

TERMS AND CONDITIONS FOR ELECTRONIC PAYMENT

By signing below, your company agrees to accept payment by BlueCross BlueShield of South Carolina and/or BlueChoice HealthPlan of South Carolina (BlueCross/BlueChoice HealthPlan), through electronic funds transfers (EFT). Additionally, you acknowledge and agree that all payments shall be made in accordance with the information that you supply on the Electronic Funds Transfer Authorization Form and that BlueCross and/or BlueChoice HealthPlan shall be entitled to rely exclusively upon such information. The terms and conditions outlined herein shall apply to and amend all existing agreements between you and BlueCross BlueShield of South Carolina and/or BlueChoice HealthPlan and/or Companion Benefit Alternatives by incorporating the following terms and conditions for electronic payment. On behalf of BlueCross BlueShield of South Carolina and BlueChoice HealthPlan, Companion Benefit Alternatives (CBA) administers behavioral health benefits. CBA is a separate company.

BlueCross/BlueChoice HealthPlan will initiate payment to you based on the following:

1. The electronic funds transfer will be made to the financial institution and account number indicated on your Electronic Funds Transfer Authorization Form.

2. BlueCross/BlueChoice HealthPlan will make payments in accordance with and be governed by the National Automated Clearinghouse Association's Corporation Trade Payment Rules. Our process is governed by and in accordance with the laws, other than choice of law provision of any particular contract, of South Carolina, including Article 4A of the Uniform Commercial Code as enacted by South Carolina and amended from time to time.

3. The information you provide on the Electronic Funds Transfer Authorization Form is very important. **You understand that you must communicate <u>any</u> change in the information to BlueCross/BlueChoice HealthPlan. This communication must be in the form of a new Electronic Funds Transfer Authorization Form faxed to this number/address:**

   803-870-8065

   Attn: EFT Coordinator

   BlueCross/BlueChoice HealthPlan/Companion Benefit Alternatives shall not be liable for any loss, which may arise solely by reason of error, mistake or fraud regarding this information.

4. Payment shall be made pursuant to the terms of the commercial agreement(s) you have executed with BlueCross and/or BlueChoice HealthPlan. The terms and conditions of the Electronic Funds Transfer Authorization Form neither expand nor diminish the respective rights and obligations of any applicable commercial agreement you have executed with BlueCross and/or BlueChoice HealthPlan. The payment due date is not affected. We will consider payment made when your financial institution has received or has control of the payment transaction. This will generally occur within three calendar days following initiation by BlueCross/BlueChoice HealthPlan.

   If payment is initiated on a non-banking day at BlueCross/BlueChoice HealthPlan's originating bank, the funds transfer will occur the following banking day. In all cases, "Banking Day" is defined as the day on which both trading partners' banks are available to transmit and receive these funds transfers.

5. BlueCross/BlueChoice HealthPlan has the right to adjust future payments if payments previously made are found to be duplicates, in excess of requirements, fraudulent or in error.

6. With respect to the EFT reimbursement process, BlueCross/BlueChoice HealthPlan shall be responsible up to the point when your financial institution receives or has control of the transaction. Any loss of data at or after that point will be borne by you unless the loss is due solely to negligence of BlueCross/BlueChoice HealthPlan or its originating bank.

   You should notify BlueCross/BlueChoice HealthPlan immediately via fax if payment is not received as described in item #4 (above). On receipt of a returned Automated Clearinghouse notification from the applicable bank, BlueCross/BlueChoice HealthPlan shall have reasonable time (not to exceed 10 business days) to make any payment.

   Your signature below constitutes a waiver on behalf of your company of any further notice related to institution of payment through EFT, and your company agrees to accept such change upon BlueCross/BlueChoice HealthPlan's receipt of this executed document as well as the EFT Authorization Form enclosed herein. If you contend payment through EFT is adverse to your company, please provide written notice of such to the fax number in #3 above immediately and in any event, no later than within 30 days.

NAME: _____ SIGNATURE: _____

(Print)

TITLE: _____ DATE: _____

GROUP NAME: _____ TAX ID: _____