ELECTRONIC FUNDS TRANSFER (EFT)

PART I – REASON FOR SUBMISSION	
Reason for Submission:	☐ New EFT Authorization
	☐ Revision to Current Authorization (*e.g. account or bank changes*)
Chain Home Office Organization	☐ Check here if EFT payment is being made to the Home Office of Chain (*Attach letter authorizing EFT payment to Chain Home Office*)

PART II – PROVIDER OR SUPPLIER INFORMATION	
Name	
Provider/Supplier Legal Business Name	
Chain Organization Name	
Home Office Legal Business Name (*if different from Chain Organization Name*)	
Tax Identification Number: (Designate ☐ SSN or ☐ EIN)	
Medicare Identification Number *(If issued)*	
National Provider Identifier (NPI)	

PART III – DEPOSITORY INFORMATION (Financial Institution)				
Depository Name				
Street Address				
City		State		Zip Code
Depository Telephone Number				
Depository Contact Person				
Depository Routing Transit Number (*nine digit*)				
Depositor Account Number				
Type of Account (*check one*)	☐ Checking Account ☐ Savings Account			
Please confirm account information is accurate.				

PART IV – CONTACT PERSON		
First Name	Middle Initial	Last Name
Telephone Number	Fax Number *(if applicable)*	
Address Line 1 *(Street Name and Number)*		
Address Line 2 *(Suite, Room, etc.)*		
City/Town	State	Zip Code + 4
E-mail Address		

PART V- AUTHORIZATION

I hereby authorize the Health Plans, hereinafter called the CONTRACTOR, to initiate credit entries, and in accordance with 31 CFR part 210.6(f) initiate adjustments for any credit entries made in error to the account indicated above. I hereby authorize the financial institutions/bank named above, hereinafter called the DEPOSITORY, to credit and/or debit the same to such account.

If payment is made to an account controlled by a Chain Home Office, the Provider of Service hereby acknowledges that payment to the Chain Office under these circumstances is still covered payment to the Provider, and the Provider authorizes the forwarding of the Health Plan payments to the Chain Home Office.

If the account is drawn in the Physician's or Individual PRACTITIONER'S Name, or the Legal Business Name of the Provider/Supplier, the said Provider or Supplier certifies that he/she has sole control of the account referenced above and certifies that all arrangements between the Depository and the said Provider or Supplier are in accordance with all applicable Medicare regulations and instructions.

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until the CONTRACTOR has received written notification from me of its termination in such time and such manner as to afford the CONTRACTOR and the DEPOSITORY reasonable opportunity to act on it. The CONTRACT will continue to send the direct deposit to the DEPOSITORY indicated above until notified by me that I wish to change CONTRACTOR and updated EFT Authorization Agreement.

Signature Line

Authorized/Delegated Official Name (Print) _____

Authorized/Delegated Official Title _____

Authorized/Delegated Official Signature _____ Date _____

I understand in receiving Electronic Funds Transfers that payment may be from Federal and State funds and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.

PRIVACY ACT ADVISORY STATEMENT

Sections 1842, 1862(b) and 1874 of title XVIII of the Social Security Act authorize the collection of this information. The purpose of collecting this information is to authorize electronic funds transfers.

Return To:
Email: Providerservices@integranethealth.com
Fax: 832-320-7200
Mail: 2900 North Loop West, #700 Houston, Texas 77092