ELECTRONIC FUND TRANSFER (EFT) AUTHORIZATION AGREEMENT

Provider Information

Type of Authorization (check one): ☐ New ☐ Change		Tax Payer ID# (TIN):	
Provider Name:		Provider NPI Number:	
Provider Accounting Street Address:			
Provider City:		State:	Zip Code:
Provider Phone:		Provider Fax:	
Provider E-mail:			

Bank Information ***Please include a voided check upon submission or a letter from your financial institution indicating bank information.***

Bank Name:			
Bank Address:			
Bank City:		State:	Zip:
Bank Phone:			
Bank Routing#:		Bank Account#:	
Practice as: ☐ PCP ☐ Specialist	Accepting New Patients: ☐ Yes ☐ No		
Languages spoken by office staff:			

I (we) hereby authorize Community Health Options to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I am (we are) responsible for the validity of the information on this form. If Community Health Options erroneously deposits funds into my (our) account, I (we) authorize Community Health Options to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay cycle.

I (we) agree to comply with all certification and credentialing requirements of Community Health Options and the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by Community Health Options or its authorized affiliate(s) or subcontractor(s). I (we) understand that payment of claims will be made from federal and state funds, and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to clients covered by programs offered through Community Health Options in accordance with applicable state and federal laws, rules, and regulations.

Authorizing Signature ______________________ Date Signed ______________________

Printed Name ______________________ Title of Signatory ______________________

Form Submission Information

*Forms must be mailed-in or scanned and sent by e-mail to: Provider@HealthOptions.org. Fax copies **WILL NOT** be acceptable.

COMMUNITY HEALTH OPTIONS
ATTN: PROVIDER RELATIONS
MAIL STOP 100
P.O. BOX 1121
LEWISTON, ME 04243

Please include a voided check upon submission or a letter from your financial institution indicating bank information.

Revised 08/03/15