



AUTHORIZATION AGREEMENT FOR DIRECT DEPOSITS (ACH CREDITS)

**** Select one of the following ****

Provider Name: _____ **Provider NPI Number:** _____

Group Name (if requested for entire group): _____ **Group NPI Number:** _____

I (we) hereby authorize Community Health Choice, Inc., to initiate one of the following on my behalf:

Electronic Remittance Advice (835 ERA) via CHC secure HTTP/FTP without Electronic Funds Transfer (EFT);

-OR-

Electronic Funds Transfer credit and, if necessary, debit entries and adjustments for any credit entries in error to my (our): (select one)

Checking Account or Savings Account

indicated below, at the depository Financial Institution named below, and credit or debit the same from such account. I (we) acknowledge that the authority will remain in effect until I have (or either of us) cancelled it in writing and that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

Financial Institution _____ Branch _____

Address _____ City _____ State _____ Zip _____

Routing Number _____ Account Number _____

EFT Agreement to: **(Select One)**

Add EFT

Change EFT

Cancel EFT

EFT Payments apply to: **(Select One)**

Claim Check only

Capitation Check only

Both Claim and Capitation Check

I (we) elect to receive the payments by the following method: **(Select One)**

Payment through Electronic Funds Transfer (EFT) with a continuation of paper EOB

Electronic Funds Transfer (EFT) and Electronic Remittance Advice via CHC Website
Paperless (Paper EOB would be discontinued): Yes No

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (835 ERA) via CHC secure HTTP/FTP
Paperless (Paper EOB would be discontinued): Yes No

This authorization is to remain in full force and effect until Community Health Choice, Inc. has received written notification from me (or either of us) of its termination in such time, and in such manner as to afford Community Health Choice, Inc. and Financial Institution a reasonable opportunity to act on it.

Tax ID Number _____ Signature _____

Contact Name _____ Contact # _____ Date _____

This Authorization may be faxed to 713-295-7055 – Attn: Network Management

