



Inland Empire Health Plan

## ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

This form is being completed in response to:

- Fax
  Receipt via Mail
  IEHP's website
  New Contract with IEHP

**Directions:** Complete all information and attach a voided check or an image of the voided check to this form. You have the option of: (1) mailing the completed form to: Accounts Payable, PO BOX 1800, Rancho Cucamonga, CA 91729-1800, (2) faxing it to (909) 890-5752 or (3) e-mail it to [vendormaintenance@iehp.org](mailto:vendormaintenance@iehp.org)

### Application and Authorization for Vendor Direct Deposits

#### REASON FOR SUBMISSION

- New Setup
  Cancellation
  Change Financial Institution
  Change Account Number

#### PAYEE IDENTIFICATION *(all fields required)*

Provider/Vendor Name
Provider/Vendor TIN <i>(Tax Identification Number)</i>
Provider E-mail
Provider Contact Phone Number
Provider Street Address
Provider City
Provider State
Provider Zip Code
Provider NPI

John Smith 123 Your Street Anywhere, USA 12345	63-88 670	0555
PAY TO THE ORDER OF _____		20
YOUR BANK 000-001 123 Main Street Anywhere, USA 12345		\$ [ ] DOLLARS
FOR	[ ] : [ ]	SAMPLE (NON-NEGOTIABLE)
ABA Number	Account Number	

#### FINANCIAL INFORMATION

*(all fields required)*

Financial Institution (Depository) Name
Transmit/ABA Number <i>(9 digits)</i>
Account Number
Financial Institution Street Address
Financial Institution City
Financial State
Financial Zip Code
Requested EFT Start/ Change/ Cancel Date

Printed Name of Person Submitting Enrollment
Signature of Person Submitting Enrollment
Printed Title of Person Submitting Enrollment
Submission Date

We authorize Inland Empire Health Plan to initiate credit entries to the account indicated above and the financial institution named above hereinafter called Depository, to credit the same to such account. It is our responsibility to notify IEHP Provider Services at (909) 890-2054 within a reasonable time if we become aware of any changes in status or banking information. It is our responsibility to notify Provider Services within a reasonable time if we believe there is a discrepancy between the amount deposited directly to our bank account and the amount of the invoices/claims paid. This authority is to remain in full force and effect until IEHP has received written notification from us of its termination in such time and in such manner as to afford IEHP and Depository a reasonable opportunity to act on it.



Inland Empire Health Plan

## Instructions for completing the EFT Enrollment form

Please type or print legibly.

Use only black ink or blue ink to complete paper form.

Online form can be accessed at [www.iehp.org](http://www.iehp.org)

**For questions about the electronic funds transfer enrollment process, send an email to Vendor Maintenance at [vendormaintenance@iehp.org](mailto:vendormaintenance@iehp.org)**

### Reason for Submission

**New Setup** – New EFT enrollment

**Cancellation** – Cancel current enrollment

**Change Financial Institution** – Change Bank Information

**Change Account Number** – Account number change only

### Payee Identification - Please fill out completely

**Provider/Vendor Name** – Complete legal name of institution, corporate entity, practice, individual name or DBA, if applicable

**Provider Federal Tax Identification Number (TIN)** – A TIN is used to identify business entity

**Provider Email Address** – An electronic mail address at which the health plan might contact the provider

**Provider Contact Telephone Number** – Telephone number of provider contact with extension, if applicable

**Provider Physical Street Address** – The number and street where a person or organization can be found

**City** – City associated with provider address field

**State** – ISO 3166-2 two character code associated with the state

**Zip Code/Postal Code** – System of postal-zone codes

**Provider National Provider Identifier (NPI)** - A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard.

The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

### Financial Information

**Financial Institution Name** – The official name of the provider's financial institution

**Transmit/ABA Number** – A 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited

**Account Number** – Provider's account number at the financial institution to which EFT payments are to be deposited

**Financial Institution Physical Street Address** - The number and street associated with receiving depository financial institution name field

**City** – City associated with provider address field

**State** – ISO 3166-2 two character code associated with the state

**Zip Code/Postal Code** – System of postal-zone codes

**Requested EFT Start/Change/Cancel Date** – Date the provider wishes to begin receiving EFTs, change data, or cancel the EFT process

### Include with Enrollment Submission

**Voided Check** – Voided check is attached to provide confirmation of the Identification/Account Numbers

**Bank Letter** – A letter on bank letterhead that formally certifies the account owners routing and account numbers

### Authorized Signature

**Printed Name of Person Submitting Enrollment** – The printed name of the person signing the form; may be used with electronic and paper-based manual enrollment

**Signature of Person Submitting Enrollment** – A (electronic or cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity

**Printed Title of Person Submitting Enrollment** – The printed title of the person signing the form; may be used with electronic or paper-based manual enrollment

**Submission Date** – The date on which the enrollment form is submitted