PROVIDER network solutions

Electronic Funds Transfer (EFT) Request Form

Provider Information

Practice Name _____

Address _____

City _____ State _____ Zip Code _____

Practice Contact _____ Phone _____

E-Mail Address _____

Please select if you refuse, or accept EFTs. If you refuse, you may skip to the signature and contact portion of the form (bottom)

I Accept ◯ I Refuse ◯

Provider Bank Information

Bank Name _____

Address _____

City _____ State _____ Zip Code _____

Account Contact _____ Phone _____

ABA Routing # _____ Account # _____

Account Type Checking ◯ Savings ◯ Preferred Payment Type Electronic ◯ Paper ◯

Healthcare Claim Payment / Advice (835)

VAN Name _____
(Optum, Availity, Emdeon, etc.)

Interchange Receiver ID VIA NETWORK PROVIDER PORTAL
(Number assigned to you by your VAN)

Preferred EOB Type Electronic ◉ Paper ◯

Claims Resolution Communication

Notes Request Responder _____
(Name and Email)

General Communication _____
(Name and Email)

Authorized Practice Rep Signature _____

Signee Email _____ Signee Phone _____ Date _____