PEOPLES HEALTH

Electronic Funds Transfer (EFT) Enrollment Form

All fields are required. Sections left blank or illegible sections will delay processing. All providers who bill under the enrolled tax ID number will receive EFT.

PRACTICE INFORMATION	
Name	Tax ID Type EIN ☐ SSN ☐ Tax ID Number
Telephone ( )	Fax Number ( )
Contact Name	Primary Email Address
Primary Service Address	Primary Billing Address

Note About Explanations of Payment (EOPs): After enrolling in EFT with Peoples Health, paper EOPs will no longer be sent to you, effective the date of the EFT setup. If you are not currently receiving an 835 file, sign up with Change Healthcare at *www.changehealthcare.com* to receive regular electronic remittance advice. Complete the **ERA Provider Setup Form** (the Peoples Health payer ID number is **72126**). If you need assistance signing up, call Change Healthcare at 1-866-817-3813.

BANKING INFORMATION	
You must include a voided check or bank letter with your enrollment application. Deposit slips and starter checks are not accepted. To take advantage of EFT, your bank must be a participating member of the National Automated Clearing House Association. Following the EFT effective date, an EFT pre-notification (pre-note) period will run approximately 7 to 10 days. New EFT enrollment or changes to existing EFT banking information will trigger a new EFT pre-note period. You are responsible for notifying Peoples Health of banking information changes.	
Bank Name	Bank Address
Routing Number	Account Number
	Account Type Savings ☐ Checking ☐

If you are requesting a change to your bank or bank account number, the following information is required:

Previous Bank Name _____ Previous Bank Address _____

Previous Routing Number _____ Previous Account Number _____

Previous Account Type Savings ☐ Checking ☐

AUTHORIZATION AGREEMENT (Please read and sign on the next page)

I hereby authorize Peoples Health to initiate credit entries to the bank account listed above for all benefits payments. This agreement will remain in effect until I notify Peoples Health of my desire to cancel or change this service or until Peoples Health notifies me that this service has been terminated. I understand I must allow up to 30 business days for my instructions to be executed. I authorize and request the bank listed above to accept any credit entries by Peoples Health to such account and to credit the same to such account.

Peoples Health will not debit or deduct funds directly from my bank account for claim overpayments or refund requests, but Peoples Health will seek permission to debit my bank account for any adjustments or corrections to resolve duplicate payments (where "duplicate" is defined as Peoples Health sending multiple identical payments in error) or erroneous payments. Peoples Health will attempt to recover the duplicate or erroneous payment via a debit to my account to the extent permitted by state law and with prior contact to me. If an electronic debit is unsuccessful, Peoples Health will notify me in writing to reach an alternative arrangement for reimbursement.*

*Peoples Health strictly adheres to National Automated Clearing House Association guidelines.

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Two different signatures are required, one healthcare professional authorized on the EFT bank account and one supervisor-level authorized representative. If a sole proprietorship, only one signature is needed. **Incomplete or illegible signature blocks will delay processing.**	
By signing below, I hereby agree that I have read and agree to the terms and conditions stated on the previous page.	
Signature 1: Authorized healthcare professional (M.D., CFO, CEO, etc.)	
Name _____	Title _____
Signature _____	Date _____
Signature 2: Supervisor-level healthcare representative (office manager, billing manager, etc.)	
Name _____	Title _____
Signature _____	Date _____
Form completed by (if different from above) _____ (print name)	Phone _____ Email _____

Peoples Health may follow up with the supervisor-level representative to ensure accuracy of the banking information.

Email completed forms and a voided check or bank letter to **phn.provider@peopleshealth.com (preferred method)**, or fax completed forms and a voided check or bank letter to 504-849-6916.