Electronic Funds Transfer (EFT) Authorization Agreement

Type of Authorization (check one): ___ **NEW** ___ **CHANGE**

Tax Payer ID# (TIN) ___ ___ - ___ ___ ___ ___ ___ ___ ___

Provider Name	**9-digit Medicaid ID # (TPI #)**	**Provider NPI Number**
Provider Accounting Address	**Phone Number**	**FAX Number**
Bank Name	**ABA/Transit Number (bank routing number)**	
Bank Street Address	**Account Number**	
Bank City/State/Zip	**Provider e-Mail Address**	
Bank Phone Number	**Type of Account (check only one)**	
	____ Checking **____ Savings**	
	PLEASE ATTACH A VOIDED CHECK.	

I (we) hereby authorize Driscoll Children's Health Plan (DCHP) 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 DCHP erroneously deposits funds into my (our) account, I (we) authorize DCHP 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 DCHP and the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by DCHP 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 DCHP in accordance with applicable state and federal laws, rules, and regulations.

_____ _____

Authorizing Signature Date Signed

_____ _____

Printed Name Title of Signatory

PLEASE ATTACH A VOIDED CHECK.

RETURN THIS FORM TO:

Driscoll Children's Health Plan
ATTN: EFT Enrollment Department
615 N Upper Broadway; Suite 1621
Corpus Christi, TX 78401