Electronic Funds Transfer Enrollment Form

☐ New Application ☐ Change an Existing Set up

Please complete form in its entirety and fax to 570-214-1553

***Practice Information*: (1 form for each tax identification number)**

Group Name: ______________________________
(Must be identical to name on bank account)

Tax Identification Number (TIN): ____________________
(Must be the same as on file with Health Plan)

Primary Service Address:
____
____
____

Primary Billing Address:
____
____
____

Financial Institution Information:

Bank Name: ______________________________ Address: ______________________________

Bank Routing Number (9 digits found on check, NOT deposit slip): ____ ____ ____ ____ ____ ____ ____ ____ ____

Account Number: ____________________________ Account Type: ☐ Checking ☐ Savings

Authorization Agreement for Direct Deposit of Provider Payments. Please read and sign your name below.
I hereby authorize Geisinger Health Plan, on behalf of itself and its affiliates, to initiate credit entries to the account at the bank listed above for all applicable provider payments. This agreement will remain in effect until I notify Geisinger Health Plan of the desire to cancel or change this service or until Geisinger Health Plan notifies me that this service has been terminated. I agree to provide notification of change/termination 30 days in advance. I understand that I must allow reasonable time for my instructions to be executed. If Geisinger Health Plan credits more money than the correct benefits amount to, the account due to duplicate electronic funds transfer or erroneous electronic funds transfer, I authorize Geisinger Health Plan to withdraw the overpayment electronically. I authorize and request the bank listed above to accept any credit entries by Geisinger Health Plan to such account and to credit the same to such account.

By signing below, I hereby agree that I have read and agree to the terms and conditions stated above.

Authorization Information:

Print name: ____ **Date:**______________

Health Care Professional Authorized Signature:____

Contact Name: ________________________ Telephone #:____________________Fax #:________________

Email address:______________________________

For Health Plan Use Only

Date Received:________________ Optional: Cdip #:______________ Office #:__________________