

**Claim Payment**

**EXNV**

**Electronic Funds Transfer (EFT) Authorization Agreement**

⃝ New ⃝ Change ⃝ Cancel

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| --- | --- | --- | --- |
| **Provider Name** | | **Tax ID □ EIN □ SSN** | |
| **Street** | **City** | **State** | **Zip** |
| **Provider Contact** | **Phone** | **Fax** | **\*\* Email** |
| \*\* The EOB for payment will be sent ONLY via email once you enroll to receive claim payment via EFT. If EOB should be sent to a different email, please list a different email here: | | | |
| **Financial Institution** | | **Phone** | |
| **Account Name** | **\*\* ABA/Routing No.** | | |
| **Account Type:** □ Checking □ Saving | **\*\* Account No.** | | |
| \*\* Please include a confirmation of account information on bank letterhead or a voided check for account verification. If  submitting bank letterhead, the bank officer’s name and signature is required. | | | |

Attach Voided Check Here

VOIDED CHECK COPY

I hereby authorize Imperial Insurance Companies, Inc. (IIC) to initiate credit entries to the account at the financial institution indicated above. This agreement will remain in effect until I notify IIC of any changes or corrections to my bank account information or until IIC notifies me that this service has been terminated. I understand that it will take approximately four weeks to process my enrollment, change or cancellation request from the date received by IIC. I understand that IIC reserves the right to reverse direct deposit of funds paid in error.

Approved Provider Signature (Account Holder) Date

Printed Name Request Start Date (Month/Year)

***Please send your completed form along with the voided check or bank letter to IIC by email at***

[***exchange@imperialhealthholdings.com.***](mailto:exchange@imperialhealthholdings.com.)

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