

**Claim Payment**

**EXUT**

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

⃝ New ⃝ Change ⃝ Cancel

|  |  |
| --- | --- |
| **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. Ifsubmitting bank letterhead, the bank officer’s name and signature is required. |

Attach Voided Check Here

VOIDED CHECK COPY

I hereby authorize Imperial Health Plan of the Southwest, Inc. (IIC) to initiate credit entries to the account at the financial institution indicated above. This agreement will remain in effect until I notify IHPSW of any changes or corrections to my bank account information or until IHPSW 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 IHPSW. I understand that IHPSW 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 IHPSW by email at:*** ***exchange@imperialhealthholdings.com.***

PO Box 60190 Pasadena, CA 91106 | 800-595-0619