Electronic Funds Transfer Authorization Agreement

To enroll in the Electronic Funds Transfer payment program, please fill out this form and return via:

Fax 262-721-0722 Email: providerservices@sciondental.com

Part I - Reason for Submission

☐ New EFT Authorization ☐ Revision to current EFT setup (i.e. account/bank change)

Part II - Provider or Supplier Information

Name of Payee:

Tax Identification Number: ☐ SSN ☐ EIN

Address of Payee:

Part III - Depository Information (Financial Institution)

Bank/Depository Name: ☐ Checking ☐ Savings

Depository Routing Number (nine digits - include any leading zeros):

Depository Account Number (include any leading zeros):

Part IV - Billing Contact Information

Name: Phone Number:

E-mail Address:

Part V - Authorization

I hereby authorize AmeriHealth Caritas Pennsylvania/AmeriHealth Northeast to initiate credit entries, and in accordance with 31 CFR part 210.6(f) initiate adjustments for any credit entries made in error to the account indicated above. I hereby authorize the financial institution/bank named above, hereinafter called the DEPOSITORY, to credit the same to such account. This authorization agreement is effective as of the signature date below and is to remain in full force and effect until the CONTRACTOR has received written notification from me of its termination in such time and such manner as to afford the CONTRACTOR and the DEPOSITORY a reasonable opportunity to act on it. The CONTRACTOR will continue to send the direct deposit to the DEPOSITORY indicated above until notified by me that I wish to change the DEPOSITORY receiving the direct deposit. If my DEPOSITORY information changes, I agree to submit to the CONTRACTOR an updated EFT Authorization Agreement.

Signature of Authorized Billing Contact Date