ELECTRONIC PAYMENT/REMITTANCE AUTHORIZATION AGREEMENT

PROVIDER INFORMATION

PROVIDER NAME:
PROVIDER FEDERAL TAX IDENTIFICATION NUMBER (TIN) **OR** EMPLOYER IDENTIFICATION NUMBER (EIN):
NATIONAL PROVIDER IDENTIFIER (NPI):

PROVIDER CONTACT INFORMATION

PROVIDER CONTACT NAME:
TELEPHONE NUMBER:
EMAIL ADDRESS:

FINANCIAL INSTITUTION INFORMATION

FINANCIAL INSTITUTION NAME:			
FINANCIAL INSTITUTION ROUTING NUMBER:			
TYPE OF ACCOUNT AT FINANCIAL INSTITUTION:	☐ CHECKING	☐ SAVINGS	
PROVIDER'S ACCOUNT NUMBER WITH FINANCIAL INSTITUTION:			
ACCOUNT NUMBER LINKAGE TO PROVIDER IDENTIFIER [provider preference for grouping (bulking) claim payments – must match preference for v5010 X12 835 remittance advice]:	☐ PROVIDER TAX IDENTIFIER (TIN): ☐ NATIONAL PROVIDER IDENTIFIER (NPI):	****Attach Form W9**	
REASON FOR SUBMISSION:	☐ NEW ENROLLMENT	☐ CHANGE ENROLLMENT	☐ CANCEL ENROLLMENT

EFT/ACH/835 REMITTANCE ADVICE OPTIONS

☐ EFT/ACH ONLY (PAPER EOB)

☐ EFT/ACH AND 835 ELECTRONIC REMITTANCE ADVICE (**1**)

☐ PAPER CHECK AND 835 ELECTRONIC REMITTANCE ADVICE **(1)**

(1) To receive an 835 remittance advice, provider must have a relationship with Change HealthCare Clearinghouse

CHANGE HEALTHCARE CLEARINGHOUSE ACCOUNT NUMBER:

THE EFT AUTHORIZATION MUST BE SIGNED BY AN INDIVIDUAL AUTHORIZED BY THE PROVIDER TO INITIATE, MODIFY OR TERMINATE AN ENROLLMENT.

If I have enrolled for EFT, I hereby authorize the Central States Southeast Areas Health and Welfare Fund (Fund) to deposit funds to the account indicated above at the depository financial institution named above. I acknowledge that the origination of Automated Clearing House (ACH) transactions must comply with the provisions of U.S. law. This authorization is to remain in full force and effect until the Fund has received written notification of its termination in such time and in such manner as to afford the Fund and the financial institution a reasonable opportunity to act on it. The Fund will continue to send the direct deposit to the financial institution indicated above until notified otherwise. If my financial institution information changes, I agree to submit to the Fund an updated Authorization Agreement. I certify that the information provided is true and accurate in all respects and that I have been duly authorized to perform transactions on this account.

WRITTEN SIGNATURE OF PERSON SUBMITTING ENROLLMENT:
PRINTED NAME OF PERSON SUBMITTING ENROLLMENT:
SUBMISSION DATE:

ONLINE	MAIL	FAX	CALL
Message Center at MyTeamCare.org	Provider Maintenance TeamCare PO Box 5116 Des Plaines IL 60017-5116	224-387-2540	Questions? 800-323-2190

Instructions for the Electronic Payment/Remittance Authorization Agreement

Provider Name - complete legal name of institution, corporate entity, practice or individual provider.

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) - the Federal Tax Identification Number, also known as an Employer Identification Number (EIN), used to identify the business entity.

National Provider Identifier (NPI) - covered healthcare providers must use an NPI in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position numeric identifier (a 10-digit number).

Provider contact name - name of the primary contact in the provider office for handling EFT issues.

Telephone number - the primary telephone number associated with contact the person identified above.

Email address - an electronic mail address at which the health plan might contact the person identified above. This does not have to be a personal address, but should be an address regularly monitored by the primary contact.

Financial Institution Information must only be completed if the provider requests EFT (below):

Financial Institution Name - the official name of the provider's financial institution.

Financial Institution Routing Number - the 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited.

Type of account at Financial Institution - the type of account the provider will use to receive EFT payments.

Provider's Account Number with Financial Institution - provider's account number at the financial institution to which EFT payments are to be deposited.

Account Number Linkage to Provider Identifier - the provider preference for grouping (bulking) claim payments – must match preference for v5010 X12 835 remittance advice if selected (below).

Provider Tax Identification Number (TIN) - the TIN associated with the provider's account - required.

National Provider Identifier (NPI) - the NPI associated with the provider's account - required.

Reason for Submission - state whether this is a New Enrollment or whether the provider is cancelling or changing an existing enrollment.

EFT/ACH/835 Remittance Advice Options

Select whether the provider is (1) enrolling for EFT only and would like to receive a paper EOB; (2) enrolling for EFT and would like to receive an 835 electronic remittance advice; or (3) enrolling for the 835 electronic remittance advice but would like to receive a paper check.

Change HealthCare Clearinghouse Account Number - required if the provider has elected to receive an 835 remittance advice.

Written signature of person submitting enrollment - the signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. This must be a rendering of the name unique to the particular person used as confirmation of authorization and identity if the provider is enrolling with a paper-based manual enrollment. If the provider is enrolling online through the completion of the electronic pdf form, the enrollment form must be signed with a digital signature through the HelloSign digital signature process.

Additional required attachment of Form W9 – request for taxpayer identification number and certification to be reported on Form 1099-MISC to the Internal Revenue Service.