Steward Health Care Network

HEALTH CHOICE

HEALTH CHOICE ARIZONA, INC.

ELECTRONIC FUNDS TRANSFER (EFT) / ELECTRONIC REMITTANCE ADVICE (ERA)

Attn: HCA Information Systems, 410 N. 44th Street, Suite 900, Phoenix, AZ 85008

Transaction Type

New EFT/ERA Setup ☐ **Change Account Type** ☐ **Change Financial Information** ☐ **Cancellation** ☐

Account Type

EFT ☐ **ERA** ☐ | **Send Paper EOB: Yes** ☐ **No** ☐

PAYEE IDENTIFICATION

Please include a **copy of a voided check**. Request will not be accepted without it.

Note: A separate form is required for each EIN. Enrollment for EFT and ERA is done on a per-EIN basis. Payments and/or remittance advices for all providers billing with the EIN below will be affected. This change applies to both Health Choice Arizona and Health Choice Generations.

Payee Name (as appears on W-9): ____________________

Federal Employer's Identification Number (EIN): ___ __ - __ __ __ __ __ __ __

Billing Address: ____________________

City: ____________ **State:** ______ **Zip:** _________

EFT/ERA Contact Name: ____________ **Contact Telephone:** (_______) - _______ - ________

I hereby authorize Health Choice, on behalf of itself and its affiliates, (hereinafter "Company"), to initiate credit entries to the account(s) at the bank(s) listed below for all benefits payments. This agreement will remain in effect until I notify Company of the desire to cancel or change this service or until Company notifies me that this service has been terminated. I understand I must allow reasonable time for my instructions to be executed. If Company credits more money than the correct benefits amount to the account due to duplicate electronic funds transfers (where "duplicate" is defined as multiple electronic funds transfers received for the same services rendered, the same membership, and the same dates of service) or erroneous electronic funds transfers (where "erroneous" is defined as complete electronic funds transfers received in error), I authorize Company to withdraw the overpayment. I authorize and request the bank(s) listed above to accept any credit entries by Health Choice to such account(s) and to credit the same to such account(s).

This authorization remains in effect until I submit an updated EFT Authorization Form requesting a change or termination and until such time that Health Choice Arizona has a reasonable opportunity to act on such request. If our depository information changes, I agree to submit an updated EFT authorization form to HCA, Attn: Information Systems, 410 N. 44th Street, Suite 900, Phoenix, AZ 85008. The change or revocation is effective on the day that HCA processes the request. I understand HCA may elect to mail paper checks and discontinue making electronic transfers to my account without advance notice.

I certify that I have read and agree to comply with the above HCA rules governing payments and electronic transfers as they exist on the date of my signature on this form or all subsequently adopted, amended, or repealed. I consent to, and agree to, comply with these rules even if they conflict with this authorization form. I certify that I am authorized to contract for the entity receiving deposits, pursuant to the agreement, and that all information provided is accurate.

Signature:	**Print Name and Title:**	**Date:**
____________	____________	____________

FINANCIAL INSTITUTION

Bank Name: ____________________

Bank Address: ____________ **City:** ____________ **State:** ______ **Zip:** _________

Checking ☐ **Savings** ☐ **Routing Number:** __ __ __ __ __ __ __ __ __

Account Number: __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

Signature: ____________________ **Date:** ____________________

CANCELLATION

Reason: ____________________ **Date:** ____________

FOR HEALTH CHOICE USE ONLY

Date Received: ____________ **Processed By:** ____________ **Date:** ____________

Comments: ____________________