Electronic Funds Transfer (EFT) Authorization Agreement

Provider Name	Doing Business As (DBA)
Provider Street Address	**Provider City**
Provider State/Province	**Provider ZIP Code/Postal Code**
Provider Tax Identifier (TIN) or Employer Identifier (EIN)	**National Provider Identifier (NPI)**
Assigning Authority	**Trading Partner ID**
Medicaid	
Provider Contact Name	**Provider E-Mail Address**
Provider Phone Number	**Provider Fax Number**
Financial Institution Name	**Financial Institution Street Address**
Financial Institution Telephone Number	**Financial Institution City/State/Zip**
Financial Institution Routing Number	**Type of Account at Financial Institution**
Provider's Account Number at Financial Institution	**Provider Preference for Grouping Claim Payments**
	____TIN or ____NPI (Please √ one)
Reason for Submission	
___ NEW ___ CHANGE ___ CANCEL (Please √ one)	

I (we) hereby authorize Driscoll Health Plan (DHP) to present credit entries into the bank account referenced above and the depository named above to credit the same to such account. I (we) understand that I am (we are) responsible for the validity of the information on this form. If DHP erroneously deposits funds into my (our) account, I (we) authorize DHP to initiate the necessary debit entries, not to exceed the total of the original amount credited for the current pay cycle.

I (we) agree to comply with all certification and credentialing requirements of DHP and the applicable program regulations, rules, handbooks, bulletins, standards, and guidelines published by DHP or its authorized affiliate(s) or subcontractor(s). I (we) understand that payment of claims will be made from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

I (we) will continue to maintain the confidentiality of records and other information relating to clients covered by programs offered through DHP in accordance with applicable state and federal laws, rules, and regulations.

______________________________ ______________________________

Authorizing Signature Date Signed

______________________________ ______________________________

Printed Name Title of Signatory

For the convenience of having direct deposit, you must be willing to download your EOB/EOP directly from www.driscollhealthplan.com. *No paper copies will be mailed.

RETURN THE FORM BY MAIL OR EMAIL

Driscoll Health Plan
ATTN: EFT Enrollment Department
4525 Ayers St, Corpus Christi, TX 78415
Email: DHPContracting@dchstx.org
Fax Number: 361-808-2182

***A voided check or bank letter is required to process the request**